

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

9623

Item 7 Film 2220 9-24-57 et

CERTIFICATE OF DEATH

09596

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck.				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle H. Last ADAMS				4. DATE OF DEATH Month Sept. Day 15, Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1878	
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Adams				14. MOTHER'S MAIDEN NAME Martha Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT Malinda Dorsey				Address Spencerville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsicemia 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic Hypertrophy (c) Bilateral Pyelonephritis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 yrs. 2 mos.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/1/57 , 19 57 , to 9/15/57 , 19 57 , that I last saw the deceased alive on 9/13/57 , 19 57 , and that death occurred at 2:01 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird				ADDRESS (Street, city or town, state) DATE SIGNED 9/17/57			
PHYSICIAN'S NAME (Type) J. W. Bird				M.D. Sandy Speer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.			
24a. REC'D BY REGISTRAR SEP 20 1957				24b. REGISTRAR'S SIGNATURE Francis Potter			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9592 Item 2 See Birth Cert. et. CERTIFICATE OF DEATH

09597
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>			d. STREET ADDRESS <u>1 8654 Piney Branch Road</u>		
3. NAME OF DECEASED (Type or print) <u>Infant Girl Albritten</u>			4. DATE OF DEATH <u>September 15, 1957</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>September 15, 1957</u>		9. AGE (In years lost birthday) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Baylus Richard Albritten, Jr.</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Jane Lovell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Deformities</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>(Hydrocephalus, diagnosis)</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Raymond Chinn</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Raymond Chinn, M. D. 925 Pershing Dr. Silver Spring, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u>	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE <u>9/19/57</u>			
24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>		24c. REGISTRAR'S SIGNATURE			

2075282 x 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10

10

BUREAU V. 2

SEP 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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2
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9624

CERTIFICATE OF DEATH

Reg. Dist. No.

09598 16

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 146 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2134 Newport Place, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle Pacshal Last Anderson		4. DATE OF DEATH Month September Day 5, Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Abner Anderson		14. MOTHER'S MAIDEN NAME Carrie Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-1101		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491 X Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3-4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphosarcoma, Chronic pyelonephritis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12, 1957 , to September 5, 1957 , that I last saw the deceased alive on September 5, 1957 , and that death occurred at 10:32 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/57 ACTUAL SIGNATURE Kurt W. Kohn M.D. PHYSICIAN'S NAME (Type) KURT W. KOHN, M. D. National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-1957		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
23. FUNERAL DIRECTOR'S SIGNATURE William Spangler		ADDRESS 524-8-5th NE SE		24a. REC'D BY REGISTRAR 10 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John Doe		Male		45		White		1912		New York	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician	
Teacher		Heart Disease		1957		Home		10:00 AM		J. Smith	
Signature of Informant		Relationship to Deceased		Date of Report		Place of Report		Time of Report		Signature of Registrar	
J. Doe		Son		1957		Home		11:00 AM		M. Jones	

RECEIVED
SEP 10 1957

RECEIVED
SEP 10 1957
BUREAU V. R.

9593

CERTIFICATE OF DEATH

Reg. Dist. No.

7/23

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 14 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9713 Dilton Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Margaret Last Appich		4. DATE OF DEATH Month Sept. Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-84
9. AGE (In years lost birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) D. C.
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME John McCormack	
14. MOTHER'S MAIDEN NAME (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, congestive 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerotic cardiovascular disease. DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May , 1957, to 15 Sept , 1957, that I last saw the deceased alive on 15 Sept , 1957, and that death occurred at 1:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9/15/57 DATE SIGNED ACTUAL SIGNATURE Ernest E. Harmon M.D. 9301 Colesville RD. Silver Spring PHYSICIAN'S NAME (Type) Ernest E. Harmon M.D.	
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/1957	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
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23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.	24a. REC'D BY REGISTRAR DATE 17 1957	24b. REGISTRAR'S SIGNATURE J. Nelson
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09600									
Item 18 Film 222 11-15-57 am 9625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 216									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>x2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4801 North Lane</u>					d. STREET ADDRESS <u>4801 North Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAMIE</u> <u>TOTTEN</u> <u>AULT</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marjorie A. Donnally-</u> <u>Bethesda, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deferred Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial hypertrophy</u> DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead sitting in chair</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Bruchart</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type)					DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>			22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 23 1957

RECEIVED

9626

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyd</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boyd</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Jane Austin</i>		4. DATE OF DEATH Month <i>September</i> Day <i>11</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July - 17 - 1887</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>25</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home - helping at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boyd, Md</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Henry Austin</i>		14. MOTHER'S MAIDEN NAME <i>Rhoda Ann Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>John Harrington Austin, Boyd, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral accident March 3, 1956</i> DUE TO (b) <i>High Arterial tension</i> DUE TO (c) <i>?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March - 3 - 1956</i> , to <i>Sept - 11 - 1957</i> , that I last saw the deceased alive on <i>Sept - 7 - 1957</i> , and that death occurred at <i>10 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller, M.D.</i>		DATE SIGNED <i>7 - Brooks Ave.,</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER, M.D., Gaithersburg, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-13-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>	22d. LOCATION (City, town, or nearby) (State) <i>Barnesville Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Farter, Gaithersburg, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>Charles W. Elgin</i>		DATE <i>9/13/57</i>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP. 16 1957

BUREAU V. S.

March 3 - 1957 - 11 - 07
William C. Miller, Jr.
2 - Bureau
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9594
CERTIFICATE OF DEATH

09602

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE FLORIDA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wakefield Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TITUSVILLE 48X-3	
d. STREET ADDRESS 413 PALM AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle ACTON Last Ayars		4. DATE OF DEATH Month Sept. Day 18, Year 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/71
9. AGE (In years and birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Salem, New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Acton	
14. MOTHER'S MAIDEN NAME Mary Andrews		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. James Ayars, 1904 Erie St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Disturbance DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyattsville, Maryland ONSET AND DEATH 1 day 30 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-5 , 1957, to 9-18 , 1957, that I last saw the deceased alive on 9-17 , 1957, and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md. DATE SIGNED 9/18/57			
ACTUAL SIGNATURE W B Wardrop M.D.		PHYSICIAN'S NAME (Type) William B. Wardrop, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 9/21/57	
22c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) SILVER SPRING, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REC'D BY REGISTRAR Sep 21 1957	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE L. W. Dodd	

RECEIVED

9627

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY MONTG MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 8yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) LOUISE Edolphine AYRES				4. DATE OF DEATH September 21 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 15-1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR 6 Months		IF UNDER 24 HRS. 6 Days		Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher. Retired,				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Aldoph Knabe			
14. MOTHER'S MAIDEN NAME Elizabeth Christman				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service			
16. SOCIAL SECURITY NO.				17. INFORMANT Asbury Methodist Home Records. As 1D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonitis DUE TO (c) Rheumatoid Arthritis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4 1956 , to 9-21 1957 , that I last saw the deceased alive on 9-18 1957 , and that death occurred at 1045 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sarah E. Glover M.D. 4208 Annapolis St Kensington Md 20-21-57							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-24-57		Prospect Hill		Washington. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg. Md.				24a. REC'D BY REGISTRAR Sept 24-57		24b. REGISTRAR'S SIGNATURE Abraham L. Goble	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1912-03-15	
Place of Birth		Race		Occupation		Usual Residence	
Baltimore, Md		White		Teacher		Baltimore, Md	
Cause of Death		Manner of Death		Date of Death		Place of Death	
Heart Disease		Natural		1957-09-10		Baltimore, Md	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone	
[Signature]		John Doe, M.D.		123 Main St		555-1234	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's Phone	
[Signature]		John Doe, Coroner		456 Main St		555-5678	

BUREAU V. 1

SEP 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09604

9628

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Wheaton		d. STREET ADDRESS 11209 Upton Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle P. Last Baker		4. DATE OF DEATH Month September Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/00
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Baker		14. MOTHER'S MAIDEN NAME Mary Catherine Glaize	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-12-2981	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10 , 19 57 , to 9/10 , 19 57 , that I last saw the deceased alive on 9/10 , 19 57 , and that death occurred at 9:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonenfant M.D. Sally Spry, M.D. 9/10/57 PHYSICIAN'S NAME (Type) A. D. BONENFANT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Strasburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		24. REC'D BY REGISTRAR SEP 13 1957	
25. REGISTRAR'S SIGNATURE Gertrude L. L...		26. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
Benjamin Davis		1910		Baltimore, Md.	
Age		Sex		Race	
70		Male		White	
Married		Single		Widow	
Cause of Death		Immediate Cause		Underlying Cause	
Heart Disease		Coronary Artery Disease		Atherosclerosis	
Duration of Illness		Time of Death		Place of Burial	
10 days		10:00 AM		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	

RECEIVED
SEP 13 1910
BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09605

CERTIFICATE OF DEATH

Reg. Dist. No.

9629

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home				d. STREET ADDRESS 1223 Michigan Ave. N.E.			
3. NAME OF DECEASED (Type or print) Nelly (Nellie) First Middle Last				4. DATE OF DEATH Sept. 20th Month Day Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 79 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				9b. KIND OF BUSINESS OR INDUSTRY N.Y.		9c. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY N.Y.		10c. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) N.Y.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wm. H. Clague				14. MOTHER'S MAIDEN NAME Fannie Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1225 Michigan Ave. N.E. Wash. D.C.			
17. INFORMANT Richard Clague				18. ADDRESS 1225 Michigan Ave. N.E. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 57 Hour 2:30 P. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac Md.	
20f. (City or town) Potomac				20g. (County) Potomac			
20h. (State) Md.				20i. (City or town) Potomac			
20j. (County) Potomac				20k. (State) Md.			
21. I certify that I attended the deceased from June 5 , 19 56 , to Sept. 20 , 19 57 , that I last saw the deceased alive on Sept. 20 , 19 57 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Rudnai				ADDRESS (Street, city or town, state) Potomac Md.			
DATE SIGNED Sept. 20, 1957							
PHYSICIAN'S NAME (Type) Andrew E. Rudnai							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORY Potomac Methodist Ch.		22d. LOCATION (City, town, or county) (State) Potomac Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel S. Searles				ADDRESS 3831 Ga. Ave. N.E.		24a. REC'D BY REGISTRAR SEP 27 1957	
				24b. REGISTRAR'S SIGNATURE Francis P. Poley			

BUREAU V. 8

SEP 27 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Silver Spring, Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		1 d. STREET ADDRESS <u>818 Silver Spring Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Conrad Bates</u>		4. DATE OF DEATH <u>September 1</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-04</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.S. Studio of Music</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Bates</u>		14. MOTHER'S MAIDEN NAME <u>Ada Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-4659</u>	
17. INFORMANT <u>Patient's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, terminal</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction of small intestine</u> DUE TO (c) <u>Peritoneal adhesions</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 31</u> , 19 <u>57</u> , to <u>Sept 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>918 University Blvd. East</u>		DATE SIGNED	
ACTUAL SIGNATURE <u>Eino Magi</u> M.D.			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		<u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8454 La Grange Rd.</u>	24a. REC'D BY REGISTRAR <u>J. Wilson Bodd</u>
		DATE <u>9/3/57</u>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY OF DEATH	
AGE OF DECEASED		SEX OF DECEASED	
MARRIAGE		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

RECEIVED
 SEP 5 1957
 BUREAU V. 2

9630

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 1/2</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>521 Beall Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Washington</u> <u>Beamer</u>				4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>5</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>George Beamer</u>				Address <u>521 Beall Ave. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Central anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central Thrombosis</u> DUE TO (c) <u>Central arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 wk</u> <u>Indef.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>57</u> , to <u>9/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/5</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				Rockville Md <u>9/5/57</u>			
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIAL</u>		22b. DATE THEREOF <u>9-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u>				ADDRESS <u>1401 Chapin Dr NW</u> <u>Washington DC</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10730

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

HABITATION

NO. OF DEATHS
REGISTERED

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

UNKNOWN

ILLUSTRATION

ILLUSTRATION

ILLUSTRATION

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BUREAU V. S.

SEP 6 1957

RECEIVED

9631
CERTIFICATE OF DEATH

Reg. Dist. No.

214

Item 8: 6221 10/14/57

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 692-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Rest Home		d. STREET ADDRESS 251 W. 87th St. Apt. #75	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Chantiles Last Belasco		4. DATE OF DEATH Month Sept. Day 30 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12 1/30/1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 30 Hours 19 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Clerk-Franklin		10b. KIND OF BUSINESS OR INDUSTRY 7th Bank, N.Y. City	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Chamtiles		14. MOTHER'S MAIDEN NAME Tasia Sioris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Philip Chantiles-5422 1st Pl. N.W.		Address Washington, D.C.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Core pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung (c) 6 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 week one year 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **July 10, 1957** to **Sept 30, 1957** that I last saw the deceased alive on **Sept. 30, 1957**, and that death occurred at **3:30 P.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **5600 N.H. Ave. Wash., D.C.** DATE SIGNED **9/30/57**

ACTUAL SIGNATURE **Samuel M Bageant** M.D. **5600 N.H. Ave. Wash., D.C.**

PHYSICIAN'S NAME (Type) **SAMUEL M BAGEANT**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/3/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR Oct 4 1957	24b. REGISTRAR'S SIGNATURE Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth	
John		Male		30		1927	
Place of Birth		Race		Occupation		Cause of Death	
New York		Caucasian		Belasco		Heart Disease	
Date of Death		Time of Death		Place of Death		Signature of Physician	
Oct 12, 1957		10:30 AM		Home		[Signature]	
Signature of Registrar		Signature of Medical Examiner		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10a, 11, 12, Film G221 10-15-57 et

CERTIFICATE OF DEATH

9632

Reg. Dist. No. 212

09609

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg.				c. LENGTH OF STAY IN 1b life					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First GRANT Middle U. Last BELL				4. DATE OF DEATH Month Sept. Day 28. Year 19 57					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1901			
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Grant Bell				14. MOTHER'S MAIDEN NAME Elizabeth Brooks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT Ida Mae Bell Address Dickerson, Md. R. F. #2.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Generalized Carcinomatosis 163x IMMEDIATE CAUSE (a) DUE TO (b) Carcinoma of the Rto Lung (c) 4 months Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.								INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from January, 1950 to 28 Sept, 1957 , that I last saw the deceased alive on 27 Sept, 1957 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Gordon M. Smith				M.D. BARNESVILLE, Md DATE SIGNED 28 Sept 57					
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/57		22c. NAME OF CEMETERY OR CREMATORY Martinsburg.		22d. LOCATION (City, town, or county) (State) Martinsburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR 9632 DATE 1957		24b. REGISTRAR'S SIGNATURE Charles Elgin			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Male		Male		35		Sept. 10, 1901		Maryland		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Place of Death		Physician's Signature		Hospital or Clinic	
None		None		Married		None		Sept. 10, 1957		Baltimore, Md.		J. Edgar Smith, M.D.		St. Mary's Hospital	
Signature of Informant		Relationship to Deceased		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Cemetery	
J. Edgar Smith		Son		J. Edgar Smith, M.D.		J. Edgar Smith		J. Edgar Smith		J. Edgar Smith		J. Edgar Smith		J. Edgar Smith	

RECEIVED
OCT 3 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9633

CERTIFICATE OF DEATH

09610

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg x 2	
c. LENGTH OF STAY IN 1b 10 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 206 Summit Ave.		d. STREET ADDRESS 206 Summit Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NETTIE First V Middle BEST Last		4. DATE OF DEATH Month Sept Day 10 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25 1874
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Cashell		14. MOTHER'S MAIDEN NAME Catherine A. Hobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) ##### (If yes, give branch of service) #####		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lawrence Best		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1-57 , 19 57 , to 9-10 , 19 57 , that I last saw the deceased alive on 9-10 , 19 57 , and that death occurred at 6 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Russell Ave DATE SIGNED 9-12-57			
ACTUAL SIGNATURE F.J. Broschart		M.D. 8 Russell Ave	
PHYSICIAN'S NAME (Type) F.J. Broschart		Gaithersburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 13 57	22c. NAME OF CEMETERY OR CREMATORY St Johns	22d. LOCATION (City, town, or county) (State) Olney Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE Sept 11-57		24b. REGISTRAR'S SIGNATURE Abner L. Gode	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9634

Item 7 Film 2220 9-20-57 et

CERTIFICATE OF DEATH

09611/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1203 Highland Drive</i>				d. STREET ADDRESS <i>1203 Highland Drive</i>			
3. NAME OF DECEASED (Type or print) <i>Thomas DeWitt Bittenbender</i>				4. DATE OF DEATH Month <i>Sept</i> Day <i>6</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25, 1898</i>	9. AGE (In years lost birthday) <i>61</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 57 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Motion Picture Operator</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>James B. Bittenbender</i>			
14. MOTHER'S MAIDEN NAME <i>Agnes Sitzenburger</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>578-05-6663</i>				17. INFORMANT Address <i>Mrs Pearl Bittenbender (Same)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>592x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Glomerular Nephritis</i> DUE TO (c) <i>Nephrotic Syndrome</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <i>1</i> p. m. Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Nov 2</i> , 19 <i>50</i> , to <i>Sept 6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 6</i> , 19 <i>57</i> , and that death occurred at <i>5:10</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip E. Jones</i>				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring Md</i>			
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>				DATE SIGNED <i>9/6/57</i>			
22a. BURIAL, CREMATION, REMOVAL, SPECIAL		22b. DATE THEREOF <i>9/9/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pr. Geo. Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co., 2901 14th St. N.W.</i>				ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>SEP 16 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 19 1922		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		JAN 19 1945		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1945		MOBILE, ALABAMA	
PREVIOUS MARRIAGES		DATE		PLACE		NAME		DATE		PLACE	
NONE											
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		JAN 19 1957		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		JAN 19 1957		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA	
DISEASE		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		JAN 19 1957		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA	
INJURY		DATE		PLACE		NAME		DATE		PLACE	
NONE											
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE	
JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE		PLACE	
JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA		JAMES EARL RAY		JAN 19 1957		MOBILE, ALABAMA	

BUREAU V. R.

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9635

CERTIFICATE OF DEATH

Reg. Dist. No.

09612
218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 7 yrs. 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3601-4	
4. DATE OF DEATH Month Sept Day 9 Year 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle L. Last Blades		8. DATE OF BIRTH Dec. 1, 1867	
5. SEX Female		9. AGE (In years last birthday) 89 yrs.	
6. COLOR OR RACE white		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John L. Blades		14. MOTHER'S MAIDEN NAME Elizabeth F. Gayle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia infection right (c) malnutrition	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x		INTERVAL BETWEEN ONSET AND DEATH 9-1-57	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 56 , to 9-9 , 19 57 , that I last saw the deceased alive on 9-4 , 19 57 , and that death occurred at 1:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4208 AnThony ST Kensington Md DATE SIGNED 9-9-57 ACTUAL SIGNATURE Sarah E. Glover M.D. Sarah E. Glover PHYSICIAN'S NAME (Type) Sarah E. Glover			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.		24a. REC'D BY REGISTRAR SEP 11 1957	
24b. REGISTRAR'S SIGNATURE Sarah E. Glover			

CERTIFICATE OF DEATH

8033

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. Dist. 1

NAME OF DECEASED John I. Miller		SEX Male		AGE 60	
DATE OF DEATH Sept. 11, 1957		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION None	
EDUCATION High School		RELIGION Catholic		MARITAL STATUS Married	
BIRTH DATE Jan. 1, 1897		BIRTH PLACE Maryland		FATHER'S NAME John I. Miller	
MOTHER'S NAME Mary Miller		SPOUSE'S NAME Mary Miller		SPOUSE'S DATE OF DEATH None	
DECEASED'S RESIDENCE 1234 Main St.		DECEASED'S OCCUPATION None		DECEASED'S SOCIAL SECURITY NO. None	
DECEASED'S MARITAL STATUS Married		DECEASED'S RELIGION Catholic		DECEASED'S EDUCATION High School	
DECEASED'S BIRTH DATE Jan. 1, 1897		DECEASED'S BIRTH PLACE Maryland		DECEASED'S FATHER'S NAME John I. Miller	
DECEASED'S MOTHER'S NAME Mary Miller		DECEASED'S SPOUSE'S NAME Mary Miller		DECEASED'S SPOUSE'S DATE OF DEATH None	
DECEASED'S RESIDENCE 1234 Main St.		DECEASED'S OCCUPATION None		DECEASED'S SOCIAL SECURITY NO. None	
DECEASED'S MARITAL STATUS Married		DECEASED'S RELIGION Catholic		DECEASED'S EDUCATION High School	

BUREAU V. S.

SEP 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9636

CERTIFICATE OF DEATH

09613

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3134 18th St., North	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle Tappy Last BLANKENSHIP		4. DATE OF DEATH Month September Day 28 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1903
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles TAPPY		14. MOTHER'S MAIDEN NAME Mary LOHR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Thomas P. BLANKENSHIP (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, rt. lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, metastatic DUE TO (c) Carcinoma, rt. breast INTERVAL BETWEEN ONSET AND DEATH days months 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) Metastatic Ca. of skin, axillary & mediastinal lymph nodes,			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of Item 18) pleurisy, pericardium, liver, kidneys & uterus.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 Sept. , 19 57 , to 28 Sept. , 19 57 , that I last saw the deceased alive on 28 Sept. , 19 57 , and that death occurred at 6:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-30-57			
ACTUAL SIGNATURE Wm. B. Ingram		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Wm. B. Ingram, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 19-1-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home		24a. REC'D BY REGISTRAR 9-30-57	
24b. REGISTRAR'S SIGNATURE May E. Penally			

CERTIFICATE OF DEATH

<p>1. Name of deceased (Print name and full name) JAMES EARL RAY</p>		<p>2. Date of birth (Month, day, year) May 19 1928</p>		<p>3. Sex Male</p>	
<p>4. Place of birth (City, State, Country) Jackson, Tennessee</p>		<p>5. Date of death (Month, day, year) May 14 1968</p>		<p>6. Time of death (Hour, minute) 10:00 AM</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause) Gunshot wound, self-inflicted, to the chest, at the base of the heart.</p>		<p>8. Manner of death (Choose one) (a) Natural (b) Accidental (c) Suicide (d) Homicide (e) Undetermined</p>			
<p>9. Signature of physician (Print name and full name) JAMES EARL RAY</p>		<p>10. Signature of medical examiner (Print name and full name) JAMES EARL RAY</p>			
<p>11. Signature of registrar (Print name and full name) JAMES EARL RAY</p>		<p>12. Signature of coroner (Print name and full name) JAMES EARL RAY</p>			

BUREAU V. F.

OCT 1 1957

RECEIVED

9637

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Adeline Bradburn</u>				4. DATE OF DEATH Month Day Year <u>Sept. 20 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 20, 1863</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Benjamin Longley</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Scheible</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Adeline B. Matthews 518 Phil. Ave. Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia atelectasis, rt. lin</u> <u>467.2</u> DUE TO (b) <u>Past op - med thrt</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>amputation Rt for vascular occlusion</u> 21 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, Scurvy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>57</u> , to <u>9/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>57</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace W. Bernston</u> M.D.				ADDRESS (Street, city or town, State) <u>10511 Summit Ave 9/20/57</u>			
PHYSICIAN'S NAME (Type) <u>Horace W. Bernston</u>				DATE SIGNED <u>9/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W K Thompson</u> ADDRESS <u>5732</u>				24a. REC'D BY REGISTRAR <u>W K</u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M Thompson</u>	

CERTIFICATE OF DEATH

BUREAU V. 2

SEP 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9638

CERTIFICATE OF DEATH

09615

Reg. Dist. No.

Item 4, Film G221, 10/3/57 fcy

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomena Nursing Home</u>		d. STREET ADDRESS <u>740 Silver Spring Ave</u>	
3. AGE OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bragazzi</u> Last <u></u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-73</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>740 319 000</u>	
17. INFORMANT <u>Mrs. Leon Bacek</u>		Address <u>740 Silver Spring Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 weeks</u> <u>10 year s</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1956</u> , to <u>September 24, 1957</u> , that I last saw the deceased alive on <u>September 22, 1957</u> , and that death occurred at <u>5:45 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>September 24, 57</u>			
ACTUAL SIGNATURE <u>Harry J. Kicherer</u> M.D.		PHYSICIAN'S NAME (Type) <u>Harry J. Kicherer, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>		ADDRESS <u>4812 Ta Ave NW</u>	
24a. REC'D BY REGISTRAR <u>SEP 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Pattery</u>	

CERTIFICATE OF DEATH

PLACE IN BOX		LOCAL RECORDS	
MASSACHUSETTS		LOCAL RECORDS	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
BIRTH DATE		BIRTH DATE	
BIRTH PLACE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE DATE	
MARRIAGE PLACE		MARRIAGE PLACE	
PREVIOUS MARRIAGES		PREVIOUS MARRIAGES	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
RELIGION		RELIGION	
SOCIETY		SOCIETY	
MILITARY SERVICE		MILITARY SERVICE	
REMARKS		REMARKS	

BUREAU V. R.

SEP 27 1957

RECEIVED

9639

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation				d. STREET ADDRESS Hyattstown Mill Road			
3. NAME OF DECEASED (Type or print) JOSEPHINE R. BRANDENBURG				4. DATE OF DEATH Sept. 7, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1885	
9. AGE (In years last birthday) 72 yrs.		10. UNDER 1 YEAR 0 Months 6 Days		11. IF UNDER 24 HRS. 0 Hours 6 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME John A. Baker				14. MOTHER'S MAIDEN NAME Amia Pollock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT David J. Brandenburg-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronchitis, Bilat. 450.0 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Gen'l. DUE TO (c) Arteriosclerosis, Gen'l. INTERVAL BETWEEN ONSET AND DEATH 4 days years 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 5, 1955 to Sept. 7, 1957 , that I last saw the deceased alive on Sept. 6, 1957 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9-9-57							
ACTUAL SIGNATURE Jack Schumacher M.D.							
PHYSICIAN'S NAME (Type) Jack Schumacher-Medical Bldg., Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/11/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR SEP 10 1957		24b. REGISTRAR'S SIGNATURE Bertander Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

onsivt

1029310

Hyltonville Mill Road

587, 18. 11.

Washington, D. C.

200109 81m16

David J. Brandenburg - Item 13

BUREAU A. S.

SEP 10 1957

RECEIVED

Garrett, M.

111-5550

Robert A. Montgomery-Bell, M.D.

Reg. Dist. No. 223

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and your designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH o. COUNTY <div style="text-align: center; font-size: 1.2em;">Montgomery</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Takoma Park</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">5 yrs</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">7123 723 Maple Ave.</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-size: 1.2em;">Max</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center; font-size: 1.2em;">Sept 25, 1957</div>	
5. SEX <div style="text-align: center; font-size: 1.2em;">male</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">white</div>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">7/25/1870</div>	
9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">87 yrs.</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">retired hat maker</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">USA</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">Unknown</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Unknown</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center; font-size: 1.2em;">no</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">213 18 6344</div>	
17. INFORMANT <div style="text-align: center; font-size: 1.2em;">Carrie Braver (wife)</div>		Address <div style="text-align: center; font-size: 1.2em;">Same as Item 2</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center; font-size: 1.2em;">Asphyxia</div> <div style="text-align: center; font-size: 1.2em;">974X</div> DUE TO <div style="text-align: center; font-size: 1.2em;">hanging</div> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.2em;">sudden</div>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center; font-size: 1.2em;">Hung self by neck in bath room of his home</div>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <div style="text-align: center; font-size: 1.2em;">19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <div style="text-align: center; font-size: 1.2em;">Frank J. Broschart</div>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">Frank J. Broschart</div>		DATE SIGNED <div style="text-align: center; font-size: 1.2em;">9/25/57</div>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		22b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">Sept. 28, 1957</div>	
22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">Ft. Lincoln Cemetery</div>		22d. LOCATION (City, town, or county) (State) <div style="text-align: center; font-size: 1.2em;">Prince George County, Md.</div>	
23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Arthur Walters, 254 Carroll St NW D.C.</div>		24a. REC'D BY REGISTRAR DATE <div style="text-align: center; font-size: 1.2em;">SEP 27 1957</div>	
24b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">J. Wilson</div>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 27 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09618

9640

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. STREET ADDRESS 5061 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) First Thelma Middle Flora Last Brouse		4. DATE OF DEATH Month September Day 1 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/00
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Groves		14. MOTHER'S MAIDEN NAME Ada Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 9040	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cedens - carcinoma left Breast 170 X DUE TO (b) Melanoma, Internal. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Pathological fracture right hip INTERVAL BETWEEN ONSET AND DEATH 1 year 6 mos 1 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9040			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall fracture right hip	
20c. TIME OF INJURY Month, Day, Year Hour o. m. not known		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shenandoah		20f. (City or town) (County) (State) Montgomery	
21. I certify that I attended the deceased from 8/28/57 , 19 57 , to 9/1/57 , 19 57 , that I last saw the deceased alive on 8/30/57 , 19 57 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		DATE SIGNED 9/3/57	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-3-57	
22c. NAME OF CEMETERY OR CREMATORY Remington		22d. LOCATION (City, town, or county) (State) Remington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		24a. REC'D BY REGISTRAR SEP 5 1957	
ADDRESS 4812 Ga. Ave. N.W.		24b. REGISTRAR'S SIGNATURE Gertrude Lawley	

SEP 5 1957

RECEIVED

12-1-54

9597

CERTIFICATE OF DEATH

09619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1957</u>				5. NAME OF DECEASED (Type or print) <u>Harry Steven Burke</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucas.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't worker</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Thomas Burke</u>		14. MOTHER'S MAIDEN NAME <u>Hester Lincoln</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Chart of Pt.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential hypertension</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Thrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 2</u> , 19 <u>57</u> , to <u>Sept. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 2</u> , 19 <u>57</u> , and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>Washington Sanitarium</u> DATE SIGNED <u>September 3, 1957</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.M. Clambes</u> ADDRESS <u>1400 Chapin St. N.W. WASH. D.C.</u>				24a. REC'D BY REGISTRAR <u>P 6</u> DATE <u>1957</u> 24b. REGISTRAR'S SIGNATURE <u>Jackson Raddy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRY STEVEN BURKE		2. SEX M	
3. AGE 15-31-1893		4. RACE W	
5. DATE OF DEATH 15-31-1893		6. PLACE OF DEATH BALTIMORE, MD	
7. CAUSE OF DEATH DIPHTHERIA		8. PLACE OF BIRTH BALTIMORE, MD	
9. OCCUPATION LABORER		10. MARITAL STATUS SINGLE	
11. SIGNATURE OF PHYSICIAN J. H. BURKE		12. SIGNATURE OF REGISTRAR J. H. BURKE	
13. SIGNATURE OF WITNESSES J. H. BURKE		14. SIGNATURE OF DECEASED HARRY STEVEN BURKE	

RECEIVED
SEP 6 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09620

9641

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>9626 Dilston Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Catherine</u> Last <u>Butt</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12/1877</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Frank Chapman</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Evelyn R. Clagett</u>		Address <u>Rockville, Md. 212 W. Mont. Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery</u> DUE TO (c) <u>Coronary A.S.D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>24 hr.</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intestinal Obstruction & secondary anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1</u> , 19 <u>57</u> , to <u>9/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>57</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u>		M.D.		ADDRESS (Street, city or town, state) <u>Rockville Md.</u>		DATE SIGNED <u>9/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Thompson</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>9-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

Birth certificate

Physician: The law requiring physician

BUREAU V. S.

SEP 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

09642

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairway Hills M.P.O. Wash. 16, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>6209 Crathie Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Roscoe</u> Last <u>Cade</u>				4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/86</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>practice of law</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>William Bartholomew Cade</u>				14. MOTHER'S MAIDEN NAME <u>Anna Pillman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Helen C. Cade</u>		Address <u>6209 Crathie Lane Washington 16, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arterio Sclerosis - Brain softening</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour a. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u></u> , to <u>8 SEPT</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 SEPT</u> , 19 <u>57</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Ball</u>				ADDRESS (Street, city or town, state) <u>7936 Georgetown Rd. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				DATE SIGNED <u>8 SEPT 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

hours after death: Page 4

be executed within

requires that the di

AL OR ATTENDING PHYSICIAN

ained by the hospital or attending

TO FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the registrar must detach the top page and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1. Name of Deceased: *William Reese*
2. Date of Death: *8/21/57*
3. Place of Death: *2209 Christie Lane*
4. Age: *78*
5. Sex: *M*
6. Race: *W*
7. Cause of Death: *Heart Disease*
8. Physician: *John G. Ball*
9. Burial Place: *Cedar Hill*
10. Date of Burial: *8/22/57*
11. Signature of Physician: *John G. Ball*
12. Signature of Registrar: *John G. Ball*

BUREAU V. 2

SEP 11 1957

RECEIVED

1. Name of Deceased: *William Reese*
2. Date of Death: *8/21/57*
3. Place of Death: *2209 Christie Lane*
4. Age: *78*
5. Sex: *M*
6. Race: *W*
7. Cause of Death: *Heart Disease*
8. Physician: *John G. Ball*
9. Burial Place: *Cedar Hill*
10. Date of Burial: *8/22/57*
11. Signature of Physician: *John G. Ball*
12. Signature of Registrar: *John G. Ball*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9643

CERTIFICATE OF DEATH

09622

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 9803 Parkwood DRIVE			
3. NAME OF DECEASED (Type or print) First GABRIELLA Middle E. Last CALDWELL				4. DATE OF DEATH Month SEPT. Day 30 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 2, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY (RETIRED)	
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME P.W. ELLIS	
14. MOTHER'S MAIDEN NAME LILLIE BELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MRS. MARTHA BROACH 9803 PARKWOOD DR. BETHESDA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 10 hrs. 5-6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/1 , 19 56 to 9/30 , 19 57 , that I last saw the deceased alive on 9/30 , 19 57 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Seymour Greenbaum M.D.				ADDRESS (Street, city or town, state) 9300 Ewing Dr. Bethesda, Md.			
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.				DATE SIGNED 9/30/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 10/3/57		22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Columbus, Mississippi	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 10-1-57	
24b. REGISTRAR'S SIGNATURE Jessie M. Thompson							

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1920		Baltimore, Md.		Jan 15, 1965		Baltimore, Md.		Heart disease		Natural		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1965	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of birth	
Jane Doe		Wife		123 Main St.		Baltimore		Md.		21201		555-1234		Jane Doe		J. Doe, M.D.		Jan 15, 1965		Jan 15, 1965		Jan 1, 1920	
25. Name of informant		26. Relationship		27. Address		28. City		29. State		30. Zip		31. Telephone		32. Signature of informant		33. Signature of registrar		34. Date of registration		35. Date of death		36. Date of birth	
John Doe		Son		456 Main St.		Baltimore		Md.		21201		555-1234		John Doe		J. Doe, M.D.		Jan 15, 1965		Jan 15, 1965		Jan 1, 1920	

BUREAU V. S.

OCT 3 1967

RECEIVED

9644

CERTIFICATE OF DEATH

Reg. Dist. No. 215

Item 13 Film G 221 10-8-57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>2379 Rhode Island Ave., N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Ray</u> Last <u>CAMPBELL</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 September 1918</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joe CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>Minnie B. WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Wife) Mrs. Helen D. CAMPBELL (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma with</u> <u>162X</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.	Month <u>19</u>	Day <u>19</u>	Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>27 Aug.</u> , 19 <u>57</u> , to <u>3 Sept.</u> , 19 <u>57</u> that I last saw the deceased alive on <u>3 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:20 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Douglas R. Koth</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-3-57</u>			
PHYSICIAN'S NAME (Type) <u>Douglas R. Koth, LT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers, 1400 Chapin St., N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>9-3-57</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

CERTIFICATE OF DEATH

09624

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 124 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Cole Last Carroll				4. DATE OF DEATH Month September Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1926	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 3 Days 1 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Traffic Engineering		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles L. Carroll, Sr.				14. MOTHER'S MAIDEN NAME Alice Cole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 214-20-5363		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INSUFFICIENCY 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC EPITHELIAL CELL CARCINOMA DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 WKS. 10 MONS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from May 20 , 19 57 , to September 21 , 19 57 , that I last saw the deceased alive on September 21 , 19 57 , and that death occurred at 12:46p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert Weiger, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/22/57			
PHYSICIAN'S NAME (Type) ROBERT WEIGER, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Fredrick Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan				ADDRESS 3818 Roland Ave		24a. REC'D BY REGISTRAR SEP 25 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

25 25 1957

RECEIVED

9598

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>4817</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paschal Ralph Chambers</u>				4. DATE OF DEATH Month Day Year <u>Sept. 12 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-88</u>	9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>J. William Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>navy</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Myocardial & Aortic Atherosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12/2/56</u> <u>317/57.</u> <u>1951</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month <u>Feb</u>	Day <u>23</u>	Year <u>1947</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>7030 Carroll Ave</u>	(County) <u>Thomson</u> (State) <u>md</u>
21. I certify that I attended the deceased from <u>Feb 23, 1947</u> to <u>Sept 12, 1957</u> , that I last saw the deceased alive on <u>Sept 12, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. I. Swoise</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Thomson Md</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Humphrey</u>				DATE SIGNED <u>9/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>SEP 16 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Thomson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-4-54

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. TIME OF DEATH		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF CLERGYPERSON		19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERGYPERSON		25. SIGNATURE OF BURIAL OFFICIAL	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CLERGYPERSON		30. SIGNATURE OF BURIAL OFFICIAL	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CLERGYPERSON		35. SIGNATURE OF BURIAL OFFICIAL	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CLERGYPERSON		40. SIGNATURE OF BURIAL OFFICIAL	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CLERGYPERSON		45. SIGNATURE OF BURIAL OFFICIAL	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CLERGYPERSON		50. SIGNATURE OF BURIAL OFFICIAL	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF CLERGYPERSON		55. SIGNATURE OF BURIAL OFFICIAL	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF CLERGYPERSON		60. SIGNATURE OF BURIAL OFFICIAL	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CLERGYPERSON		65. SIGNATURE OF BURIAL OFFICIAL	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESS		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF CLERGYPERSON		70. SIGNATURE OF BURIAL OFFICIAL	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF CLERGYPERSON		75. SIGNATURE OF BURIAL OFFICIAL	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF CLERGYPERSON		80. SIGNATURE OF BURIAL OFFICIAL	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF CLERGYPERSON		85. SIGNATURE OF BURIAL OFFICIAL	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF CLERGYPERSON		90. SIGNATURE OF BURIAL OFFICIAL	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF CLERGYPERSON		95. SIGNATURE OF BURIAL OFFICIAL	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF CLERGYPERSON		100. SIGNATURE OF BURIAL OFFICIAL	

BUREAU V. 1

SEP 16 1957

RECEIVED

9599

CERTIFICATE OF DEATH

09626

Reg. Dist. No. 21-3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN b <u>1 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>7019 Georgia Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>First Earnest Middle alexander Last Cole</u>		4. DATE OF DEATH <u>9-7-1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Guard - U.S. Supreme Court.</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Preston Cole</u>		14. MOTHER'S MAIDEN NAME <u>Frances McGown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W. W. I. Navy</u>		16. SOCIAL SECURITY NO. <u>Records - + Daughter</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>8 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 1954, to <u>Sept 7</u> , 1957, that I last saw the deceased alive on <u>Sept 7</u> , 1957, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James C Mandes</u>		ADDRESS (Street, city or town, state) <u>1801 K ST N.W.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JAMES C MANDES</u>		<u>WASHINGTON, D.C.</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIED</u>	22b. DATE THEREOF <u>SEPT 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee F. Walters</u>		24a. REC'D BY REGISTRAR <u>175 CARROLL ST NW</u>	24b. REGISTRAR'S SIGNATURE <u>John D. Dadd</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0962716

Reg. Dist. No.

~~9646~~

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 56 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6700 Piney Branch Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First William		Middle Ide		Last Coleman	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH September 22, 1957	
9. AGE (In years lost birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teletype Analyst		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert E. Coleman				14. MOTHER'S MAIDEN NAME Mary Edith Slack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-07-8631		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 28, 1957 , to September 22, 1957 , that I last saw the deceased alive on September 22, 1957 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/23/57 ACTUAL SIGNATURE James C. Allen M.D. National Institutes of Health PHYSICIAN'S NAME (Type) James C. Allen, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24 1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters				24a. REC'D BY REGISTRAR SEP 24 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1910		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Carpenter		Myocardial Infarction		Natural		JAN 25 1957		BALTIMORE, MARYLAND	
Physician		Date of Death		Time of Death		Time of Day		Time of Year	
JAMES H. HARRIS		JAN 25 1957		10:30 AM		10:30 AM		JAN 25 1957	
Physician		Date of Death		Time of Death		Time of Day		Time of Year	
JAMES H. HARRIS		JAN 25 1957		10:30 AM		10:30 AM		JAN 25 1957	

BUREAU V. 3

SEP 24 1957

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Handwritten notes and signatures at the bottom of the form.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9647 CERTIFICATE OF DEATH

Reg. Dist. No.

096287

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 8 hrs, 10 min					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.				d. STREET ADDRESS Woodbine 06 X 2.2					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Cook				4. DATE OF DEATH Month September Day 3 Year 19 57					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/57			
9. AGE (In years last birthday) yrs. 8		10. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.					
13. FATHER'S NAME Edward Cook				14. MOTHER'S MAIDEN NAME Martha Ann Lowman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fetal Atelectasis DUE TO (c) Prematurity								INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Sep. 3 , 19 57 , to Sep. 3 , 19 57 , that I last saw the deceased alive on September 3 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md. DATE SIGNED ACTUAL SIGNATURE L. I. Leal M.D. Gaithersburg, Md. PHYSICIAN'S NAME (Type) L. I. Leal Gaithersburg, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9-4-1957		22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW			
22d. LOCATION (City, town, or county) (State) CARROLL CO Md.									
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Wertz Winfield, Md.				24a. REC'D BY REGISTRAR SEP 6 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lowery			

20731928VI

CERTIFICATE OF DEATH

NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]	
DATE OF DEATH [Blank]		TIME OF DEATH [Blank]		PLACE OF DEATH [Blank]	
CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]		PLACE OF BIRTH [Blank]	
OCCUPATION [Blank]		EDUCATION [Blank]		MARITAL STATUS [Blank]	
PREVIOUS ILLNESS [Blank]		PREVIOUS SURGERY [Blank]		PREVIOUS TRAUMA [Blank]	
PHYSICIAN'S SIGNATURE [Blank]		COUNTY HEALTH OFFICER'S SIGNATURE [Blank]		DEATH CERTIFICATE NO. [Blank]	
DATE OF SIGNATURE [Blank]		TIME OF SIGNATURE [Blank]		PLACE OF SIGNATURE [Blank]	
NAME OF WITNESS [Blank]		ADDRESS OF WITNESS [Blank]		CITY OF WITNESS [Blank]	
STATE OF WITNESS [Blank]		COUNTY OF WITNESS [Blank]		TOWNSHIP OF WITNESS [Blank]	
NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]	
DATE OF DEATH [Blank]		TIME OF DEATH [Blank]		PLACE OF DEATH [Blank]	
CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]		PLACE OF BIRTH [Blank]	
OCCUPATION [Blank]		EDUCATION [Blank]		MARITAL STATUS [Blank]	
PREVIOUS ILLNESS [Blank]		PREVIOUS SURGERY [Blank]		PREVIOUS TRAUMA [Blank]	
PHYSICIAN'S SIGNATURE [Blank]		COUNTY HEALTH OFFICER'S SIGNATURE [Blank]		DEATH CERTIFICATE NO. [Blank]	
DATE OF SIGNATURE [Blank]		TIME OF SIGNATURE [Blank]		PLACE OF SIGNATURE [Blank]	
NAME OF WITNESS [Blank]		ADDRESS OF WITNESS [Blank]		CITY OF WITNESS [Blank]	
STATE OF WITNESS [Blank]		COUNTY OF WITNESS [Blank]		TOWNSHIP OF WITNESS [Blank]	

BUREAU V. R.

SEP 6 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9648

Reg. Dist. No. 0962216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>15008 RUGBY AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>VIRGIE P.</u> Middle <u>COOKE</u> Last <u>COOKE</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 21-1877</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>1</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RICHMOND VIRGINIA</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>LEVI</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA A WATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>C.W. PORTER III</u>		17. INFORMANT <u>SON</u> Address <u>5008 RUGBY AVE. BETHESDA MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>MAY 14</u> , 1957, to <u>SEPT. 12</u> , 1957, that I last saw the deceased alive on <u>SEPT. 22</u> , 1957, and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				ADDRESS (Street, city or town, state) <u>5009 DEL RAY AVE. BETHESDA Md</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				DATE SIGNED <u>9/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>		22d. LOCATION (City, town, or county) (State) <u>Henrico County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>9-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

BUREAU V. S.

SEP 26 1957

RECEIVED

9649 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville	
c. LENGTH OF STAY IN b. 26 days		d. STREET ADDRESS Spencersville Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Josephine Last Corbin		4. DATE OF DEATH Month September Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1916
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Eichholz		14. MOTHER'S MAIDEN NAME Alvina Sommers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-4229	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Failure (c) Mitral Insufficiency			INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 1, 1957 , to September 27, 1957 , that I last saw the deceased alive on September 27, 1957 , and that death occurred at 1:17 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Waldhausen, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 9/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/1/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR SEP 30 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

SEP 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9650

09631

Reg. Dist. No.

214

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 56			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) J.C. Penny Company 8656 Colesville Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Donald M Couldren				4. DATE OF DEATH September 3 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/13	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Edward Couldren				14. MOTHER'S MAIDEN NAME Florence Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 184-09-1084			
17. INFORMANT Mrs. Grace Couldren, 2507 Kimberly St.				Address Silver Spring, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/6/57		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery	
22d. LOCATION (City, town, or county) Prince George County Md				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				ADDRESS Silver Spring, Md		24a. REC'D BY REGISTRAR 9/10/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 13 1957

RECEIVED

9617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1211 Highwood Rd.				d. STREET ADDRESS 1211 Highwood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) 66 CONSTANTINE First COUROUNIoTIS Middle Sept. 20, Last 19 57 4. DATE OF DEATH							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1889	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 8 Days 19 Hours Min. 	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook-retired				10b. KIND OF BUSINESS OR INDUSTRY employed		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen Courouniotis				14. MOTHER'S MAIDEN NAME Antonia Angelitis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Rachel Courouniotis		Address same as item 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary thrombosis DUE TO (c) coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) central thrombosis in st. hemiparesis							
INTERVAL BETWEEN ONSET AND DEATH 12 hr 24 hr Relief							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 3, 1956 to Sept 20 1957 that I last saw the deceased alive on Sept 20, 1957 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 9/20/57							
ACTUAL SIGNATURE Stephen N. Jones M.D.							
PHYSICIAN'S NAME (Type) STEPHEN N. JONES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR SEP 23 1957	
24b. REGISTRAR'S SIGNATURE Laurel Krug							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09633

9651

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>West Hyattsville 1615.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Cowburn</u> Last <u>Cowburn</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Manchester, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Cowburn</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>037-14-7496</u>	
17. INFORMANT <u>William A. Cowburn</u>		Address <u>9303 20th Ave W. Hyattsville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis Left Coronary artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>Sept 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.		ADDRESS (Street, city or town, state) <u>8248 Georgia Avenue</u>	
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS MD</u>		DATE SIGNED <u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9652

CERTIFICATE OF DEATH

09634

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital				e. STREET ADDRESS 12308 Goodhill Rd.			
3. NAME OF DECEASED (Type or print) First Bernice Middle Alice Last Creed				4. DATE OF DEATH Month 9 Day 10 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1914		9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist				10b. KIND OF BUSINESS OR INDUSTRY D.C. Police Dept.		11. BIRTHPLACE (State or foreign country) Vienna, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas E. Crowell				14. MOTHER'S MAIDEN NAME Ruby Cockrille			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Husband- Mr. Willie Creed				Address Wheaton, Maryland 12308 Goodhill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Edema 322.2 DUE TO Acute Brain Syndrome with delirium tremens and convulsive seizures. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute degeneration of liver							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept. 7 , 19 57 , to Sept. 10 , 19 57 , that I last saw the deceased alive on Sept. 10 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry E. Andrén</i>				ADDRESS (Street, city or town, state) Cedarcroft Sanitarium & Hospital			
PHYSICIAN'S NAME (Type) Henry E. Andrén, M. D.				DATE SIGNED Silver Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR SEP 16 1957	
				24b. REGISTRAR'S SIGNATURE <i>Francis P. Potts</i>			

BUREAU V. S.

SEP 16 1957

RECEIVED

9670

CERTIFICATE OF DEATH

Reg. Dist. No.

7-3

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & Hospital				d. STREET ADDRESS 8702 Gilbert Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GRATTON - PAINTER CREGER				4. DATE OF DEATH 9 - 27 1957			
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/6/99	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Norfolk Western Railroad		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CHARLES CREGER				14. MOTHER'S MAIDEN NAME Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Douglas L Cregier Address 8702 Gilbert Pl. Takoma Park.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral lobal pneumonia DUE TO (c) 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 25 , 19 57 , to Sept 27 , 19 57 , that I last saw the deceased alive on Sept 27 , 19 57 , and that death occurred at 9:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Raymond O. West				ADDRESS (Street, city or town, state) 7600 Carroll Ave Takoma Park			
DATE SIGNED md.							
PHYSICIAN'S NAME (Type) RAYMOND O. WEST							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR SEP 30 1957 24b. REGISTRAR'S SIGNATURE John L. Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Form No. 1

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL CLASS [Faint text]		12. CAUSE OF DEATH [Faint text]	
13. PLACE OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]		16. PLACE OF INTERMENT [Faint text]		17. NAME OF FUNERAL HOME [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	

RECEIVED
 SEP 30 1957
 BUREAU V. S.

9653

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4513 Sleaford Road				d. STREET ADDRESS 4513 Sleaford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE J. DALEY				4. DATE OF DEATH Sept. 24, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mch 13, 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 8 Days 11		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME George J. Daley				14. MOTHER'S MAIDEN NAME Mary Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-03-9595		17. INFORMANT Mrs Teresa G. Daley-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 15 min. 2 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 24, 19 57 to Sept. 24, 19 57 , that I last saw the deceased alive on Sept. 24, 19 57 , and that death occurred at 12:30 P. M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Leo M. Curtis M.D. 8218 Wisconsin Ave Bethesda, Md.							
PHYSICIAN'S NAME (Type) Leo Curtis				8218 Wis. Ave., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur. Transf.		9/25/57		Elks		Asbury Park, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 9-26-57		24b. REGISTRAR'S SIGNATURE Bernard M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

RECEIVED
SEP 30 1957
BUREAU V. 4

9654

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia 75x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>?</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Delaplane</u> Middle Last				4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24-1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. RR</u>		11. BIRTHPLACE (State or foreign country) <u>Hancock-Maryland</u>	
13. FATHER'S NAME <u>James Delaplane</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>716-09-3524</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fever-Typhoid - 3 weeks influenza</u> 12 hrs <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility + debility + emaciation</u> 10 yrs. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-15-</u> , 19 <u>54</u> , to <u>9-7-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-20-</u> , 19 <u>57</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D. <u>Olney Md</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>9 Sept 1957</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. THOMAS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HANCOCK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphey</u> ADDRESS <u>SILVER SPRING, MD</u>				24. REC'D BY REGISTRAR DATE <u>SEP 10 1957</u> 25. REGISTRAR'S SIGNATURE <u>Estelle L. Lander</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUROAU V. 3

SEP 10 1957

RECEIVED

9655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Viers Mill Village				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4205 Ivy Glen Rd.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Viers Mill Village			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4205 Ivy Glen Rd.			
3. NAME OF DECEASED (Type or print) First VINIA Middle BOGGS Last De WITT				4. DATE OF DEATH Month Sept. Day 27, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 14, 1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 5 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Andrew Boggs				14. MOTHER'S MAIDEN NAME ? Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband Herbert E. DeWitt		Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Vulva 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 to 9/27 1957 , that I last saw the deceased alive on 8/31/57 , 19 57 , and that death occurred at 1:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4709 Montgomery Lane DATE SIGNED 							
ACTUAL SIGNATURE Paul D. Cantor				M.D. 4709 Montgomery Lane			
PHYSICIAN'S NAME (Type) PAUL D. CANTOR				4709 Montgomery Lane, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/1957		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Montgomery Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10-2-57		24b. REGISTRAR'S SIGNATURE Laurel Kragtorp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

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HEALTH DEPARTMENT

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1997

WILSON
MONTGOMERY COUNTY

BUREAU V. 5

1957 7 190

RECEIVED

09639 216

9656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7218 Chestnut Street				d. STREET ADDRESS 7218 Chestnut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Donelon				4. DATE OF DEATH Month Day Year Sept 16 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, L & M Railroad				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Patrick Donelon				14. MOTHER'S MAIDEN NAME Mary Donelon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Address John Donelon 7218 Chestnut St. C.C., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis cerebral thrombosis							INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>Sept 15 1956</u> , that I last saw the deceased alive on <u>Sept 15 1956</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1150 G. Medical Bldg. N.W. Wash. D.C. 9-16-57							
ACTUAL SIGNATURE Wesley M. Oler M.D. Wesley M. Oler							
PHYSICIAN'S NAME (Type) Wesley M. Oler							
22a. BURIAL OR CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/16/57		22c. NAME OF CEMETERY OR CREMATORY New St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR SEP 17 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BU

SEP 17 1957

RECEIVED

9657

CERTIFICATE OF DEATH

09640
Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 11 dyas	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Fletcher Last Dorsey		4. DATE OF DEATH Month September Day 20 Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Dorsey		14. MOTHER'S MAIDEN NAME Martha Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chronic Pyelonephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus - 2 yrs.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 55 to September 20 , 19 58 , that I last saw the deceased alive on September 19, 1957 , and that death occurred at 4:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Md. DATE SIGNED			
ACTUAL SIGNATURE Christine A. D. M.D.		PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/22/57	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swarden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR SEP 24 1957	24b. REGISTRAR'S SIGNATURE Christine A. D.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 217

9658

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Brookville Derwood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Brookville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gordon Apts.		d. STREET ADDRESS 1 Gordon Apts	
3. NAME OF DECEASED (Type or print) First Debra Middle MARIE Last Doss		4. DATE OF DEATH Month Sept Day 18 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26, 1952
9. AGE (In years last birthday) 4 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Florenteen Doss		14. MOTHER'S MAIDEN NAME Dorla Maxine Argenbright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Dorla Doss Address Brookville, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Sarcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcinoma of eyelid, rt. (c) —			INTERVAL BETWEEN ONSET AND DEATH 1 day 5 mo. 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/17, 1957 to 9/18, 1957 , that I last saw the deceased alive on 9/17, 1957 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Higdon, MD		ADDRESS (Street, city or town, state) Sandy Spring, MD.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 9/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/20/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR SEP 20 1957	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Gertrude Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be needed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		DATE OF DEATH <i>Sept 18 1957</i>	
AGE <i>45</i>		SEX <i>M</i>	
RACE <i>W</i>		MARRIAGE <i>Married</i>	
BIRTH DATE <i>1912</i>		BIRTH PLACE <i>MD</i>	
EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>	
RESIDENCE <i>123 Main St, Baltimore, MD</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. K. Brown</i>		SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE <i>Sept 20 1957</i>		DATE OF SIGNATURE <i>Sept 20 1957</i>	

BUREAU V. 5

SEP 20 1957

RECEIVED

9601

CERTIFICATE OF DEATH

Reg. Dist. No.

0964273

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 17			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON San. & Hospital				d. STREET ADDRESS 7909 GREENWOOD AVE.			
3. NAME OF DECEASED (Type or print) JAMES BALDWIN				4. DATE OF DEATH SEPTEMBER 14 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/12/02	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTO		11. BIRTHPLACE (State or foreign country) DIST. of Columbia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME CHARLES Otis DOTEN				14. MOTHER'S MAIDEN NAME ZARA BALDWIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-03-8188		17. INFORMANT SON		Address 7909 Greenwood AVE. TAKOMA PARK, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Pneumonia - Rt. Upper Lobe 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyloric obstruction DUE TO (c) Old duodenal ulcer							INTERVAL BETWEEN ONSET AND DEATH 48 hours Two months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from OCT. 1953 to Sept 14, 1957 that I last saw the deceased alive on Sept 14, 1957 , and that death occurred at 12:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Merrill M. Cross				ADDRESS (Street, city or town, state) 8248 GEORGIA AVE		DATE SIGNED 9/14/57	
PHYSICIAN'S NAME (Type) MERRILL M. CROSS				SILVER SPRING, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/57		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cem.		22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR SEP 17 1957	
				24b. REGISTRAR'S SIGNATURE J. Nelson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09643

9659

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington				d. STREET ADDRESS 2633 Garfield St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE RUSSELL DOWLING				4. DATE OF DEATH Month Day Year September 1 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 April 1879	
9. AGE (In years lost, birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Bissell TALCOTT				14. MOTHER'S MAIDEN NAME Deretta Florence GOFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Daughter) Ellen Condon DOWLING (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, left lung 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 August , 19 57 , to 1 Sept. , 19 57 , that I last saw the deceased alive on 1 September , 19 57 , and that death occurred at 9:25 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wm. B. Ingram U.S. Naval Hospital, Bethesda, Md. 9-3-57							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) Wm. B. INGRAM, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Smith, Hawes Sons ADDRESS Cawler's & Sons, 1756 Penn. Ave., Washington, D.C.				24a. REC'D BY REGISTRAR DATE 9-3-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WU 1000 STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

SEP 4 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

09645713

9602

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. LENGTH OF STAY IN 1b <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. & Hosp.</u>				d. STREET ADDRESS <u>1830 University Blvd.</u>			
3. NAME OF DECEASED (Type or print) <u>Marguerite Mary Edwards</u>				4. DATE OF DEATH <u>Sept. 16 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13 1897</u>	9. AGE (In years, lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>57</u>		IF UNDER 24 HRS. Months <u>16</u> Days <u>19</u> Hours <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Norton</u>			
14. MOTHER'S MAIDEN NAME <u>Marion Berry</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Charlotte S. Marshall, 8009 Eastern Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemic pneumonia</u> 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Suppurative bronchitis</u> DUE TO (c) <u>Bronchiectasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wk</u> <u>2 wk plus</u> <u>2 wk plus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month <u>9</u> Day <u>16</u> Year <u>1957</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-12, 1957</u> , to <u>9-16, 1957</u> , that I last saw the deceased alive on <u>9-16, 1957</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. DANISH</u>				ADDRESS (Street, city or town, state) <u>922 Rushing Rd Silver Spring Md</u>			
DATE SIGNED <u>9-16-57</u>				M.D. <u>9-16-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>			
24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9660

CERTIFICATE OF DEATH

09646

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 ROCKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>506 DEAN DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DIANE</u> Middle <u>EMPLETON</u> Last <u>EMPLETON</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 26 - 1951</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BERNARD E. EMPLETON</u>				14. MOTHER'S MAIDEN NAME <u>ANITA RICHARDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NO -</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphocytic leukemia</u> <u>204.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>56</u> , to <u>9-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-17</u> , 19 <u>57</u> , and that death occurred at <u>1:11 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Hall</u>				DATE SIGNED <u>6:56 Montgomery Ave Rockville, Md 9/17/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Pamphrey</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN W. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Mobile, Ala.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. EDUCATION <i>High School</i>	
9. RELIGION <i>Methodist</i>		10. RACE <i>White</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. PLACE OF DEATH <i>Home</i>		14. TIME OF DEATH <i>10:30 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>J. H. Jones</i>		16. SIGNATURE OF REGISTRAR <i>W. B. Smith</i>	
17. DATE OF DEATH <i>Sept 10 1957</i>		18. TIME OF DEATH <i>10:30 AM</i>	
19. PLACE OF DEATH <i>Home</i>		20. TIME OF DEATH <i>10:30 AM</i>	
21. PLACE OF DEATH <i>Home</i>		22. TIME OF DEATH <i>10:30 AM</i>	
23. PLACE OF DEATH <i>Home</i>		24. TIME OF DEATH <i>10:30 AM</i>	
25. PLACE OF DEATH <i>Home</i>		26. TIME OF DEATH <i>10:30 AM</i>	
27. PLACE OF DEATH <i>Home</i>		28. TIME OF DEATH <i>10:30 AM</i>	
29. PLACE OF DEATH <i>Home</i>		30. TIME OF DEATH <i>10:30 AM</i>	
31. PLACE OF DEATH <i>Home</i>		32. TIME OF DEATH <i>10:30 AM</i>	
33. PLACE OF DEATH <i>Home</i>		34. TIME OF DEATH <i>10:30 AM</i>	
35. PLACE OF DEATH <i>Home</i>		36. TIME OF DEATH <i>10:30 AM</i>	
37. PLACE OF DEATH <i>Home</i>		38. TIME OF DEATH <i>10:30 AM</i>	
39. PLACE OF DEATH <i>Home</i>		40. TIME OF DEATH <i>10:30 AM</i>	
41. PLACE OF DEATH <i>Home</i>		42. TIME OF DEATH <i>10:30 AM</i>	
43. PLACE OF DEATH <i>Home</i>		44. TIME OF DEATH <i>10:30 AM</i>	
45. PLACE OF DEATH <i>Home</i>		46. TIME OF DEATH <i>10:30 AM</i>	
47. PLACE OF DEATH <i>Home</i>		48. TIME OF DEATH <i>10:30 AM</i>	
49. PLACE OF DEATH <i>Home</i>		50. TIME OF DEATH <i>10:30 AM</i>	
51. PLACE OF DEATH <i>Home</i>		52. TIME OF DEATH <i>10:30 AM</i>	
53. PLACE OF DEATH <i>Home</i>		54. TIME OF DEATH <i>10:30 AM</i>	
55. PLACE OF DEATH <i>Home</i>		56. TIME OF DEATH <i>10:30 AM</i>	
57. PLACE OF DEATH <i>Home</i>		58. TIME OF DEATH <i>10:30 AM</i>	
59. PLACE OF DEATH <i>Home</i>		60. TIME OF DEATH <i>10:30 AM</i>	
61. PLACE OF DEATH <i>Home</i>		62. TIME OF DEATH <i>10:30 AM</i>	
63. PLACE OF DEATH <i>Home</i>		64. TIME OF DEATH <i>10:30 AM</i>	
65. PLACE OF DEATH <i>Home</i>		66. TIME OF DEATH <i>10:30 AM</i>	
67. PLACE OF DEATH <i>Home</i>		68. TIME OF DEATH <i>10:30 AM</i>	
69. PLACE OF DEATH <i>Home</i>		70. TIME OF DEATH <i>10:30 AM</i>	
71. PLACE OF DEATH <i>Home</i>		72. TIME OF DEATH <i>10:30 AM</i>	
73. PLACE OF DEATH <i>Home</i>		74. TIME OF DEATH <i>10:30 AM</i>	
75. PLACE OF DEATH <i>Home</i>		76. TIME OF DEATH <i>10:30 AM</i>	
77. PLACE OF DEATH <i>Home</i>		78. TIME OF DEATH <i>10:30 AM</i>	
79. PLACE OF DEATH <i>Home</i>		80. TIME OF DEATH <i>10:30 AM</i>	
81. PLACE OF DEATH <i>Home</i>		82. TIME OF DEATH <i>10:30 AM</i>	
83. PLACE OF DEATH <i>Home</i>		84. TIME OF DEATH <i>10:30 AM</i>	
85. PLACE OF DEATH <i>Home</i>		86. TIME OF DEATH <i>10:30 AM</i>	
87. PLACE OF DEATH <i>Home</i>		88. TIME OF DEATH <i>10:30 AM</i>	
89. PLACE OF DEATH <i>Home</i>		90. TIME OF DEATH <i>10:30 AM</i>	
91. PLACE OF DEATH <i>Home</i>		92. TIME OF DEATH <i>10:30 AM</i>	
93. PLACE OF DEATH <i>Home</i>		94. TIME OF DEATH <i>10:30 AM</i>	
95. PLACE OF DEATH <i>Home</i>		96. TIME OF DEATH <i>10:30 AM</i>	
97. PLACE OF DEATH <i>Home</i>		98. TIME OF DEATH <i>10:30 AM</i>	
99. PLACE OF DEATH <i>Home</i>		100. TIME OF DEATH <i>10:30 AM</i>	

RECEIVED
SEP 28 1957
BUREAU V. 1

CERTIFICATE OF DEATH

Reg. Dist. No.

223

9603

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>7139 Maple Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Patrick Jerome Etherson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-19-87</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Packing Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.J.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Etherson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McIntyre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1904</u>				16. SOCIAL SECURITY NO. <u>PT's Chart</u>		17. INFORMANT Address <u>PT's Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gargene, early, rt. long extremity</u> 450.1 DUE TO <u>Embolism, rt. common iliac artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, lower aorta, with thrombosis</u> DUE TO (c) <u>Arteriosclerosis, lower aorta, with thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old cystic neovasis, rt. cerebral hemisphere, due to arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1957</u> Hour <u>9</u> a. m. <u>26</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7401 BLAIR Road NW</u>	
20f. (City or town) <u>Wash. DC</u>				(County) <u>DC</u>		(State) <u>DC</u>	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>10</u> , <u>9/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>57</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Hobbs</u>				DATE SIGNED <u>7401 BLAIR Road NW</u>			
PHYSICIAN'S NAME (Type) <u>Chau H. W. L. H. N.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>J. Arthur Walters</u>		24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9661

CERTIFICATE OF DEATH

09648

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>1 9914 MONTAUK AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>DOROTHY</u> Middle <u>SPRINGER</u> Last <u>FAIRFIELD</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 21-1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROCUREMENT CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL MED. CEN.</u>		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>HARRY E SPRINGER</u>				14. MOTHER'S MAIDEN NAME <u>ABBE ANN HALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO.</u>			
17. INFORMANT <u>MR. HAROLD N. FAIRFIELD - HUSBAND</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Adenocarcinoma of Ovaries</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>6 mo</u> <u>4 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>50</u> , to <u>9/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>57</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Jagger</u>				ADDRESS (Street, city or town, state) <u>5707 WISCONSIN AVE</u>			
PHYSICIAN'S NAME (Type) <u>FRANK JAGGERS</u>				DATE SIGNED <u>9/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 9-17-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 18 1957

RECEIVED

CERTIFICATE OF DEATH

9662

09649
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9630 Parkwood Drive				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salem 83X-3			
				d. STREET ADDRESS Rt. # 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle D. Last FARLEY, Sr.				4. DATE OF DEATH Month September Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/98		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 5 Days 12	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Elkhorn, W. Va.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Wm. H. Farley				14. MOTHER'S MAIDEN NAME Florence Ellison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Rachel H. Farley-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute Left Ventricular Distention DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Diffusion				INTERVAL BETWEEN ONSET AND DEATH 1-2 mon			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8-14 19 57 , to 9-4 19 57 , that I last saw the deceased alive on 9-3- 19 57 , and that death occurred at 1:15 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm Fleet Luckett				ADDRESS (Street, city or town, state) DATE SIGNED 5000 Penn Rd NW Wash DC			
PHYSICIAN'S NAME (Type) Wm. Fleet Luckett							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur.-Transit 9/6/57				Ferguson		Roanoke Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 9-4-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 6 1957

BUREAU V. 3

STATE OF TEXAS		COUNTY OF DALLAS	
CERTIFICATE OF DEATH			
Name of Deceased		John D. Ramsey, Sr.	
Age		38 years	
Sex		Male	
Race		White	
Date of Birth		September 2, 1919	
Place of Birth		Dallas, Texas	
Cause of Death		Heart Disease	
Date of Death		September 2, 1957	
Place of Death		Dallas, Texas	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9663

CERTIFICATE OF DEATH

09650

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Kensington Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 KENSINGTON GARDENS</u>				d. STREET ADDRESS <u>3000 McComas Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>J.</u> Last <u>FARRAR</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1886</u> 70 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept Gov</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Parkinson's disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Sept 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 19</u> , 19 <u>57</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold F. McCann</u> M.D.				ADDRESS (Street, city or town, state) <u>3008-14th N.W.</u>		DATE SIGNED <u>9/24/57</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>				Work <u>Wash.</u>		D.C.	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>				24a. REC'D BY REGISTRAR <u>PC</u>		24b. REGISTRAR'S SIGNATURE <u>James P. Lacey</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Sept 25, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
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70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
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85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. B.

SEP 27 1957

RECEIVED

9664

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Drummond Avenue				d. STREET ADDRESS 4510 Drummond Avenue			
3. NAME OF DECEASED (Type or print) First MARY Middle ANGELA Last FENWICK				4. DATE OF DEATH Month SEPT. Day 3 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1874	9. AGE (In years last birthday) 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10b. KIND OF BUSINESS OR INDUSTRY own home			11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Ignatius J. Fenwick				14. MOTHER'S MAIDEN NAME Julia M. Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Orlene Fenwick- same as Item 2D			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic cardiac-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis + senile changes DUE TO (c) 10-7-57						INTERVAL BETWEEN ONSET AND DEATH 10-7-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic congestive heart failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May , 19 51 , to Sept 3 , 19 57 , that I last saw the deceased alive on 9/3 , 19 57 , and that death occurred at 7:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3100 Conn. Ave. DATE SIGNED 9/3/57							
ACTUAL SIGNATURE John V. Dolan		M.D. 3100 Conn. Ave.		DATE SIGNED 9/3/57			
PHYSICIAN'S NAME (Type) John V. Dolan		3100 Conn. Ave. N. W.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/6/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 9-4-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 1

SEP 6 1957

RECEIVED

9665

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>109 NORTH BROOK LANE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>P.</u> Last <u>FERNALD</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 26-1893</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL TEACHER</u>		11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE W FERNALD</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA GRAHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>SISTER</u>		Address <u>BETH. MD. 9118 REDWOOD AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>2 1/2 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March, 1957</u> , to <u>Sept 22, 1957</u> , that I last saw the deceased alive on <u>Sept 19, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. Joyce</u>				ADDRESS (Street, city or town, state) <u>8106 Maple Ridge Rd, Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>Wm. Joyce</u>				DATE SIGNED <u>9/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumpfrey-Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>9-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Humphrey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]
2. SEX: [Illegible]
3. AGE: [Illegible]
4. DATE OF BIRTH: [Illegible]
5. PLACE OF BIRTH: [Illegible]
6. OCCUPATION: [Illegible]
7. CAUSE OF DEATH: [Illegible]
8. PLACE OF DEATH: [Illegible]
9. DATE OF DEATH: [Illegible]
10. SIGNATURE OF PHYSICIAN: [Illegible]
11. SIGNATURE OF REGISTRAR: [Illegible]
12. SIGNATURE OF WITNESS: [Illegible]

BUREAU V. S.

SEP 26 1957

RECEIVED

13. NAME OF PHYSICIAN: [Illegible]
14. NAME OF REGISTRAR: [Illegible]
15. NAME OF WITNESS: [Illegible]
16. NAME OF PHYSICIAN: [Illegible]
17. NAME OF REGISTRAR: [Illegible]
18. NAME OF WITNESS: [Illegible]

9666

214

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

NEW YORK AND STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF CHURCH CLERK		17. SIGNATURE OF MINISTER		18. SIGNATURE OF RABBI	
19. SIGNATURE OF PRIEST		20. SIGNATURE OF MINISTER		21. SIGNATURE OF RABBI	
22. SIGNATURE OF PRIEST		23. SIGNATURE OF MINISTER		24. SIGNATURE OF RABBI	
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94. SIGNATURE OF PRIEST		95. SIGNATURE OF MINISTER		96. SIGNATURE OF RABBI	
97. SIGNATURE OF PRIEST		98. SIGNATURE OF MINISTER		99. SIGNATURE OF RABBI	
100. SIGNATURE OF PRIEST		101. SIGNATURE OF MINISTER		102. SIGNATURE OF RABBI	

RECEIVED
OCT 4 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9667
CERTIFICATE OF DEATH

09654

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSURANCE 5077 Bradley Blvd.		d. STREET ADDRESS 5077 Bradley Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAE First GIRARD Middle FRAME Last		4. DATE OF DEATH SEPTEMBER 6th. 1957. Month Sept Day 6th Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Louisiana	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alcee Girard		14. MOTHER'S MAIDEN NAME EMERITE PROVOST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS DUNCAN BROOKS Address 8503 Irvington St. Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 14	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY , 19 57 , to Sept 6 , 19 57 , that I last saw the deceased alive on Sept. 2 , 19 57 , and that death occurred at 3:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4702 Montgomery Lane Bethesda Md 9-6-57			
ACTUAL SIGNATURE Paul D. Cantor		PHYSICIAN'S NAME (Type) Paul D Cantor	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		24a. REC'D BY REGISTRAR DATE 9 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

WYLAND STATE DEPARTMENT OF HEALTH—SALTWATER 18

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BUREAU

SEP 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809655
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9668

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 6 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8704 Sundale Drive		e. STREET ADDRESS 8704 Sundale Drive	
3. NAME OF DECEASED (Type or print) William Joseph Gallagher		4. DATE OF DEATH Sept. 6, 1957	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 9, 1904	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stock Market	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Gallagher		14. MOTHER'S MAIDEN NAME Margaret Tracy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 7042-578-46-	
17. INFORMANT Margaret Gallagher (wife)		Address Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in bed. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. Burial		22b. DATE THEREOF 9/9/57	
22c. NAME OF CEMETERY OR CREMATORY Pittston, Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR SEP 10 1957		24b. REGISTRAR'S SIGNATURE Francis Pitter	

SEP 10 1957

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TABLE 1. *Continued*

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• *Journal of the American Medical Association*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09656216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u> d. STREET ADDRESS <u>12058 Milton St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Garber</u>				4. DATE OF DEATH Month Day Year <u>Sept 15, 1957</u> <u>19</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Mayer Barr</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Morris Goldstein</u> <u>12058 Milton St. S.S., Md.</u> Same as Item # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Accident</u> DUE TO (b) <u>Hypertention</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetis (mild) 5 yrs.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5 yrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/15/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>Sept. 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth Shalom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hillside, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky & Sons</u>				24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie Thompson</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH-BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
HARRY J. HARRIS		Male		35		10-1-57	
Place of Birth		Cause of Death		Manner of Death		Occupation	
New York City		Heart Disease		Natural		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
 SEP 18 1957
 BUREAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No.

216

9670

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Central America b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) El Salvador 90 X-3			
3. NAME OF DECEASED (Type or print) First Otto Middle Rene Last Garcia				4. DATE OF DEATH Month September Day 16 , Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1955	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Central America	
12. CITIZEN OF WHAT COUNTRY? Central America							
13. FATHER'S NAME Arturo Garcia				14. MOTHER'S MAIDEN NAME Blanca L. Nisthal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Insufficiency (c) Tetralogy of Fallot INTERVAL BETWEEN ONSET AND DEATH 5 min 5 hours 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Surgery							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from September 4, 1957 , to September 16, 1957 , that I last saw the deceased alive on September 16, 1957 , and that death occurred at 5:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Waldhausen, M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 9/17/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 9/17/57		22c. NAME OF CEMETERY OR CREMATORY General Cemetery		22d. LOCATION (City, town, or county) (State) Guatemala City, Guatemala	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 9/18/57	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

SEP 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9671

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1212 Florida Avenue, N. W.			
3. NAME OF DECEASED (Type or print) First William Middle Joe Gartrell				4. DATE OF DEATH Month September Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1915	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Addison Gartrell				14. MOTHER'S MAIDEN NAME Angeline Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 950x Hemorrhage into chest cavity & DUE TO (b) Leaking Shack & Cordiac Arrest DUE TO (c) Post-op Repair of Atrial Septum failed & Cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 8, 1957 , to September 25, 1957 , that I last saw the deceased alive on September 25, 1957 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 9/25/57			
ACTUAL SIGNATURE C. Lombardo				M.D. National Institutes of Health			
PHYSICIAN'S NAME (Type) C. Lombardo, M. D.				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. F. Allen				ADDRESS 1200 Fla. Ave., N.W. Wn.		24a. REC'D BY REGISTRAR Beatrix Thompson	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		60		JAN 15 1897		BALTIMORE		MD		MD		USA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
White		White		Roman Catholic		Married		High School		Carpenter		Heart Disease		Natural	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH	
BALTIMORE		BALTIMORE		MD		USA		SEP 27 1957		10:00 PM		BALTIMORE		BALTIMORE	
NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN		NAME OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL		NAME OF HOSPITAL	
BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL		BALTIMORE HOSPITAL	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME		BALTIMORE FUNERAL HOME	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY		BALTIMORE CEMETERY	

RECEIVED
BUREAU V. S.
SEP 27 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

9672

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Monty</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN TB <i>1 yr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring 56</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3301 Janet Rd</i>				d. STREET ADDRESS <i>3301 Janet Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>French</i> First <i>Gibson</i> Middle <i>Gibson</i> Last				4. DATE OF DEATH <i>Sept 14 1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-5-17</i>	9. AGE (In years last birthday) <i>40</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>bulldozer operator</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>W. Va</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>Shirl Gibson</i>				14. MOTHER'S MAIDEN NAME <i>Raney Bartholow</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>World War 11 235-12-3626</i>		17. INFORMANT <i>Mr Gibson (wife)</i>		Address <i>Itun 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage & laceration</i> <i>976X</i> DUE TO (b) <i>Bullet wound thru skull</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self inflicted bullet wound thru skull</i>			
20c. TIME OF INJURY Month, Day, Year <i>9-14 1957</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) (County) (State) <i>Silver Spring Monty Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/18/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Arlington Virginia</i>		22d. LOCATION (City, town, or county) (State) <i>9-14-57</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wanner & Pumphrey</i>				ADDRESS <i>Silver Spring, Md</i>		24c. REC'D BY REGISTRAR <i>SEP 17 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
OF MARYLAND

DEPARTMENT OF HEALTH
BALTIMORE

DATE OF DEATH

PLACE HERE
THE CAUSE OF DEATH
AS DETERMINED BY YOU
OR BY THE PATHOLOGIST
WHOM YOU HAVE CONSULTED

BUREAU V. E.

SEP 17 1957

RECEIVED

9673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 193 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4415 Iowa Street, N. W.			
3. NAME OF DECEASED (Type or print) First Ada Middle Emma Last Gordon				4. DATE OF DEATH Month September Day 29 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid (Char Woman)				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James G. Wimberley				14. MOTHER'S MAIDEN NAME Josephine Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 579-50-3088		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal lymphoma, type undifferentiated 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20, 1957 to September 29, 1957 that I last saw the deceased alive on September 29, 1957 and that death occurred at 7:40 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/30/57 ACTUAL SIGNATURE J. C. Allen, M.D. M.D. PHYSICIAN'S NAME (Type) J. C. Allen, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire				24a. REC'D BY REGISTRAR OCT 4 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. No. 10

NAME (Last, First, Middle) [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		BIRTH DATE [Illegible]		BIRTH PLACE [Illegible]	
DECEASED AT [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	
ZIP CODE [Illegible]		SOCIAL SECURITY NUMBER [Illegible]		MARITAL STATUS [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
PREVIOUS ILLNESS [Illegible]		PREVIOUS SURGERY [Illegible]		PREVIOUS TRAUMA [Illegible]	
PREVIOUS DRUGS [Illegible]		PREVIOUS ALCOHOL [Illegible]		PREVIOUS TOBACCO [Illegible]	
PREVIOUS OTHER [Illegible]		PREVIOUS OTHER [Illegible]		PREVIOUS OTHER [Illegible]	

BUREAU V. 8

OCT 4 1957

RECEIVED

09661/23

CERTIFICATE OF DEATH

Reg. Dist. No.

9671

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>802 Argyle Rd. 1</u>			
3. NAME OF DECEASED (Type or print) <u>Mr. Leo Clark Gressley</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7-10-01</u>				9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Peoples Drug Store #103</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>John Clark Gressley</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>5-78095735</u>		17. INFORMANT <u>Wife</u> Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>705.4</u> DUE TO <u>Collagen Disease (Lupus Erythematosus)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>30 days</u> <u>40 days</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January</u> , 19 <u>40</u> , to <u>Sept 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 23</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Wardrop</u> M.D. <u>837 Bonifant St. Silver Spring, Md.</u>				DATE SIGNED <u>SEP 25 1957</u>			
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP, MD</u>				ADDRESS <u>837 Bonifant St. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>He S. H. Hines Co 2901 14th St N.W. DC</u>				24a. REC'D BY REGISTRAR <u>SEP 25 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dady</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 25 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington SAN. & Hospital</u>				d. STREET ADDRESS <u>8710 Cameron St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mrs. Ida</u> Middle <u>-</u> Last <u>Gudelsky</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>23</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-78</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		11. BIRTHPLACE (State or foreign country) <u>American</u>	
13. FATHER'S NAME <u>Jerome Stanley Halper</u>				14. MOTHER'S MAIDEN NAME <u>Gladys -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>Daughter Anna Gudelsky</u>		17. INFORMANT Address <u>8710 Cameron St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO <u>with Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>to liver and other organs.</u> (b) <u>2 years</u> (c) <u>157X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20, 1957</u> , to <u>Sept 23, 1957</u> , that I last saw the deceased alive on <u>Sept 23, 1957</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. B. Orleans</u>				ADDRESS (Street, city or town, state) <u>9500 Columbia Rd Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS</u>				DATE SIGNED <u>SEP 26 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-25-57</u>		<u>Arroyo Run</u>		<u>Boeto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levine</u>				24. REGISTRAR'S SIGNATURE <u>J. W. Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. DATE	

BUREAU V. 2

SEP 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

9674

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>East Baton Rouge</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>33 1/2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1001 Convention St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred</u> <u>Godlove</u> <u>Hannie</u>				4. DATE OF DEATH Month Day Year <u>9</u> <u>8</u> <u>19-57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-19-09</u>	
9. AGE (In years lost birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed manager club operator</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>George T. Hannie</u>				14. MOTHER'S MAIDEN NAME <u>Essie Sourati</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alice Hannie</u> Address <u>1001 Convention St. Baton Rouge La.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination due To</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding Esophageal Varices</u> DUE TO (c) <u>Chlriassiss of liver.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 3</u> , 19 <u>57</u> , to <u>Sept. 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 19 <u>57</u> , and that death occurred at <u>4:45 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Bailey</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Joseph A. Bailey</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. - Transit</u>		22b. DATE THEREOF <u>9/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baton Rouge, La.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *George T. Harris*
DATE OF DEATH: *11-19-57*
PLACE OF DEATH: *Home*
AGE: *78*
SEX: *Male*
RACE: *White*
MARRIAGE: *Married*
OCCUPATION: *Retired*
EDUCATION: *High School*
RELIGION: *Methodist*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *[Signature]*
DATE: *11-20-57*
PLACE: *Baltimore, Md.*

BUREAU V. 1

SEP 11 1957

RECEIVED

ROBERT J. BARNES - BALTIMORE, MD.
11-19-57 10:00 AM

9675

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Maryland</u>		d. STREET ADDRESS <u>8430 New Hampshire Ave.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Geraldne Stich HENDRIX</u>		4. DATE OF DEATH Month Day Year <u>September 14 19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 February 1915</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Arizona</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Stich</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband, Ellis H. HENDRIX (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchial asthma</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 Sept.</u> , 19 <u>57</u> , to <u>14 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>14 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>W.B. Ingram</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md. 9-14-57</u>	
PHYSICIAN'S NAME (Type) <u>W. B. INGRAM, CDR, MC USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		ADDRESS <u>1551 Wisconsin Ave., Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>9-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9676

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
3. NAME OF DECEASED (Type or print) First Edith Middle Elizabeth Last Hilts		4. DATE OF DEATH Month September Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Kenney	
14. MOTHER'S MAIDEN NAME Millie Van Curen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 086-22-1040		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC TUMORS OF LUNG. 199.9 DUE TO (PRIMARY SITES UNKNOWN) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1-2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYCOSIS FUNGOIDES, CONGESTIVE HEART FAILURE, CANCER			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 18, 1957 , to September 24, 1957 , that I last saw the deceased alive on September 24, 1957 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9/24/57	
ACTUAL SIGNATURE Richard K. Shaw		M.D. National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Richard K. Shaw, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 9/26/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Pt. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Wash, D.C.	24a. REC'D BY REGISTRAR 1957
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3078

NAME OF DECEASED MONTGOMERY		SEX Male		AGE 35		DATE OF BIRTH 1922		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several Months		PLACE OF DEATH Home	
DATE OF DEATH October 1, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME None	
NAME OF NEXT OF KIN Mrs. J. H. Smith		ADDRESS 1234 Main St., Baltimore, Md.		CITY Baltimore		STATE Maryland		ZIP CODE 21201	
NAME OF DECEASED MONTGOMERY		SEX Male		AGE 35		DATE OF BIRTH 1922		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several Months		PLACE OF DEATH Home	
DATE OF DEATH October 1, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME None	
NAME OF NEXT OF KIN Mrs. J. H. Smith		ADDRESS 1234 Main St., Baltimore, Md.		CITY Baltimore		STATE Maryland		ZIP CODE 21201	

BUREAU V. 1

OCT 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09666

9677

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitorium		d. STREET ADDRESS 6600 Luzon Ave., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BELLE HOLLANDER		4. DATE OF DEATH Month Day Year 9/22/57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Timbarov		14. MOTHER'S MAIDEN NAME Riva Shapiro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT 6600 Luzon Ave., N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis		10 years	
(c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 , 19____, to 9/22/57 , 19____, that I last saw the deceased alive on 9/22/57 , 19____, and that death occurred at 2:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Maurice Protas		ADDRESS (Street, city or town, state) DATE SIGNED 915 - 19th St. N.W. Wash. D.C. 9/22/57	
PHYSICIAN'S NAME (Type) Dr. Maurice Protas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/57	
22c. NAME OF CEMETERY OR CREMATORY Bnai Israel Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		24a. REC'D BY REGISTRAR DATE 25 1957	
24b. REGISTRAR'S SIGNATURE Bessie Thompson			

BUREAU V. 1

SEP 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9678

CERTIFICATE OF DEATH

09667 213
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Zion		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Russell Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle HOLLEY Last HOLLEY		4. DATE OF DEATH Month September Day 7 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Hall		14. MOTHER'S MAIDEN NAME Caroline Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mary Mumford Address Germantown, Md. Sister			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2 , 19 57 to 9/7 , 19 57 , that I last saw the deceased alive on 9/5 , 19 57 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. W. Bird Sandy Sp. Md 9/10/57			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 9/12/57	
22c. NAME OF CEMETERY OR CREMATORY Brownstown		22d. LOCATION (City, town, or county) (State) Germantown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		24. RECEIVED BY REGISTRAR (Date) REGISTRAR'S SIGNATURE SEP 16 1957 Dawell Proctor	

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BUREAU V. F.

SEP 16 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09668 214
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 576	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,823 DEAN ROAD			d. STREET ADDRESS 12,823 DEAN ROAD		
3. NAME OF DECEASED (Type or print) GEORGE TALBERT HUTCHINSON First Middle Last			4. DATE OF DEATH SEPTEMBER 21 Month Day Year 19 57		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26, 1891		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY THEATRE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
13. FATHER'S NAME FRANK S. HUTCHINSON			14. MOTHER'S MAIDEN NAME DORA L. WUNDERLICK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-28-8731A		17. INFORMANT Address MRS. GLENN E. FEENEY, 12,823 DEAN RD., S.S., MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					INTERVAL BETWEEN ONSET AND DEATH Found at dead in bed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED SEPT. 22, 1957	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/25/57	22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR SEP 24 1957	
				24b. REGISTRAR'S SIGNATURE Francis Patter	

STATE OF
MASSACHUSETTS

NOTES

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BUREAU V. 31

SEP 24 1957

RECEIVED

9680

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 69 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Bethesda				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			
d. STREET ADDRESS 4334 East West Highway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle (No middle name) Last Jacobsen				4. DATE OF DEATH Month September Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 26, 1945	
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		IF UNDER 24 HRS. Months 11 Days 11 Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles J. Jacobsen				14. MOTHER'S MAIDEN NAME Bess Schwartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphatic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mo.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 28 , 19 57 , to September 5 , 19 57 , that I last saw the deceased alive on September 5 , 19 57 , and that death occurred at 7:45 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/5/57							
ACTUAL SIGNATURE Dane R. Boggs				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		22d. LOCATION (City, town, or county) (State) Doelin New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE B. Waryanday + Sons				ADDRESS 3501 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 9-7-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JOHNSON		2. SEX Male		3. AGE 62 years		4. RACE White	
5. DATE OF DEATH October 12, 1957		6. TIME OF DEATH 10:30 AM		7. PLACE OF DEATH Home		8. CAUSE OF DEATH Coronary artery disease	
9. DISEASE OR INJURY Coronary artery disease		10. INTERPRETER'S SIGNATURE [Signature]		11. MEDICAL EXAMINER'S SIGNATURE [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF WITNESSES [Signatures]		14. SIGNATURE OF CLERK [Signature]		15. SIGNATURE OF REGISTRAR [Signature]		16. SIGNATURE OF CHIEF OF BUREAU [Signature]	

BUREAU V. S.

SEP 9 1957

RECEIVED

9681

CERTIFICATE OF DEATH

09670

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Sandy Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>Elmying</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Huldah</u> First <u>Janney</u> Middle <u>Janney</u> Last <u>Janney</u>				4. DATE OF DEATH <u>Sept 19 1957</u> Month <u>Sept</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 6 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathan Newson</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Newby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr Morris (Daughter)</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Fractured left hip</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yrs</u> <u>4 1/2 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell while alone in garden</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5/5</u> 19 <u>57</u> p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Sandy Spring</u> (County) <u>Montg.</u> (State) <u>MD.</u>							
21. I certify that I attended the deceased from <u>9/18/57</u> to <u>9/19/57</u> , that I last saw the deceased alive on <u>9/18/57</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. L. 1900</u>				DATE SIGNED <u>9/19/57</u>			
PHYSICIAN'S NAME (Type) <u>C. H. L. 1900</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Brinklow, Mont.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Laytonville, Md</u>				24a. REC'D BY REGISTRAR <u>9-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude B Lowler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8031

<p>1. NAME OF DECEASED <i>James James</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>7</i></p>		<p>4. DATE OF BIRTH <i>1950</i></p>	
<p>5. PLACE OF BIRTH <i>Frederick, Md.</i></p>		<p>6. PLACE OF DEATH <i>Frederick, Md.</i></p>	
<p>7. OCCUPATION <i>Student</i></p>		<p>8. CAUSE OF DEATH <i>Heart failure</i></p>	
<p>9. MANNER OF DEATH <i>Natural</i></p>		<p>10. DATE OF DEATH <i>Oct 1, 1957</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>	

BUREAU V. 3

OCT 1 1957

RECEIVED

9682

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Los Angeles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Downey 43X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 7823 Farm St. 115 Anderson Court			
3. NAME OF DECEASED (Type or print) First Calvin Middle Earl Last JENNINGS				4. DATE OF DEATH Month September Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 June 1957		9. AGE (In years last birthday) yrs. 2 19	IF UNDER 1 YEAR Months 2 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald E. JENNINGS				14. MOTHER'S MAIDEN NAME Camille E. CLEMENT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Donald E. JENNINGS (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease - truncus, septal DUE TO (c) defect						INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 28 August , 19 57 , to 9 Sept. , 19 57 , that I last saw the deceased alive on 9 August , 19 57 , and that death occurred at 6:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Daniel Shuptar M.D. U.S. Naval Hospital, Bethesda, Md. 9-9-57. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Daniel Shuptar U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE RA Ramphay 205025 2X05				ADDRESS 2555 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 9-9-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Cardiac failure

Defect

BUREAU V. S.

SEP 11 1957

RECEIVED

9683

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b x2 Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4102 Warner St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Stone Middle Johnson Last				4. DATE OF DEATH Sept. Month 21 Day 19 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1917	
9. AGE (In years lost birthday) yrs. 40		IF UNDER 1 YEAR Months 0 Days 18 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Melrose, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Fred L. Stone				14. MOTHER'S MAIDEN NAME Dorothy Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Sullivan V. Johnson, Jr.		Address 4102 Warner St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c) Malnutrition & Alcoholism						INTERVAL BETWEEN ONSET AND DEATH 2 day 1 yr Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - - - -						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/13/1957 , to 9/21/1957 , that I last saw the deceased alive on 9/21/1957 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville Md. DATE SIGNED 9/22/57			
PHYSICIAN'S NAME (Type) Stephen N. Jones, M.D.				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/23/1957		22b. DATE THEREOF Cremation		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Prince Georges Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR DATE 9-24-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 would be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9684

CERTIFICATE OF DEATH

09673

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Bradley Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD M. JOLLEY First Middle Last				4. DATE OF DEATH Sept. 17, 1957 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1877	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 1 Days 13		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contractor				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-1720		17. INFORMANT Robert H. Smith-Item # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Angina 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Thrombosis DUE TO (c) Central Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 hr. Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epidermal Skin Carcinoma & extreme emaciation						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1956 to 9/17, 1957 , that I last saw the deceased alive on 9/17, 1957 , and that death occurred at 10:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 9/18/57			
PHYSICIAN'S NAME (Type) Stephen N. Jones							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 9-19-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Robert A. Thompson-Belmont, Jr.	
Date of Death		07/19/57	
Place of Death		Baltimore, Maryland	
Age		30	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Unknown	
Cause of Death		Unknown	
Place of Birth		New York	
Date of Birth		Aug. 3, 1927	
Place of Residence		6200 Broadway Blvd.	
County		Baltimore	
State		Maryland	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Sept. 17, 1957	

BUREAU V. 2

SEP 23 1957

RECEIVED

9685

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 10308 Montgomery Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES First C. Middle JONES Last				4. DATE OF DEATH September 11, 19 57 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1899		9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months 0 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Eugene Jones				14. MOTHER'S MAIDEN NAME Clara Conley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Four Hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Sept 9, 1957 to Sept 11, 1957 that I last saw the deceased alive on Sept 10, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Beallsville, Md. DATE SIGNED 10/3/57							
ACTUAL SIGNATURE Samuel Allen M.D.							
PHYSICIAN'S NAME (Type) Samuel Allen-Kensington, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13/57	22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR OCT 8 1957		24b. REGISTRAR'S SIGNATURE Beattie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 8 1957

RECEIVED

10885

9686

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE (District of Columbia) COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN IB 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Washington 16		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5308 Falmouth Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Timothy Last Kennedy				4. DATE OF DEATH Month September Day 11 , Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1954		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Kennedy				14. MOTHER'S MAIDEN NAME Julienne Fenske			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Thrombocytopenia DUE TO (c) Acute Lymphatic Leukemia							INTERVAL BETWEEN ONSET AND DEATH 5 hours 1 month 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Staphylococcal Septicemia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957 , to September 11, 1957 , that I last saw the deceased alive on September 11, 1957 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dane R. Boggs				ADDRESS (Street, city or town, state) The Clinical Center M.D. National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Dane R. Boggs, M. D.				DATE SIGNED 9-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24. REC'D BY REGISTRAR DATE 09-18-1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9687

CERTIFICATE OF DEATH

09674

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>55 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6120 32nd Pl.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>A</u> Last <u>Lamke</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1908</u>		9. AGE (In years lost birthday) <u>49</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Atomic Energy Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Crystal Lake, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes U.S.</u>	
13. FATHER'S NAME <u>George W. Lamke</u>				14. MOTHER'S MAIDEN NAME <u>ORAH A. Ashley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wife - Edythe Lamke</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Aneurysm, Rt Middle Cerebral Artery</u> DUE TO (c) <u>2 hrs</u> 2 hrs						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>57</u> , to <u>Sept 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u>				ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave Washington DC</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>				DATE SIGNED <u>9-8-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>9-9-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The text is mirrored and appears to be bleed-through from the reverse side of the page.

BUREAU V. S.

SEP 11 1957

RECEIVED

9688

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 mos. 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5604 Montgomery Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Burrows Last LANMAN				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 April 1909	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Maurice LANMAN				14. MOTHER'S MAIDEN NAME Anna Burrows			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II 212-38-6728		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic Bronchogenic Carcinoma with Generalized Metastasis (Brain, lymph nodes). DUE TO 162X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 9 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 May , 19 57 , to 27 Sept. , 19 57 , that I last saw the deceased alive on 27 Sept. , 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-28-57							
ACTUAL SIGNATURE Thirl Jarrett M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) Thirl Jarrett, CAPT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 Oct. 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 9-28-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

NAME OF PHYSICIAN

NAME OF HOSPITAL

DATE OF DEATH

BUREAU V. B.

OCT 1 1957

RECEIVED

2-25-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09676

9639

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24812 43rd PLACE NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>1 WASHINGTON DC</u>	
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>V</u> Last <u>LEITCH</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK OF MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JULIUS VIEDT</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ZEH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-14-9703</u>	
17. INFORMANT <u>DAUGHTER</u> Address <u>NW 1620 FULLER ST.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>10 years</u> <u>1 year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Sept 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>57</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Everett</u> M.D.		ADDRESS (Street, city or town, state) <u>9400 CONN. AV. KENSINGTON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>John E. Everett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Ames Co</u> ADDRESS <u>2901 14th St NW Washington, DC</u>		24. REG'D BY REGISTRAR <u>SEP 26 1957</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>		ET	

01-27-2008 09:03 AM

BUREAU V. S.

SEP 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

773

9676

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56			
d. STREET ADDRESS 9214 Manchester Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Matilda Middle Sybelia Last Leonard				4. DATE OF DEATH Month Sept. Day 14 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/29/78	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. 79			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick Crossart				14. MOTHER'S MAIDEN NAME Sybelia Bartels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Address Same as above.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infant, parieto-temporal aneurysm, left cerebrum 332X DUE TO Thrombosis, left middle cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 days DUE TO 9 days (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, left coronary artery & infarct, left ventricle of heart							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-5- , 19 57 , to 9-14 , 19 57 , that I last saw the deceased alive on 9-14 , 19 57 , and that death occurred at 8:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9301 Colesville Rd. Silver Spring DATE SIGNED SEP 17 1957							
ACTUAL SIGNATURE Ernest E. Harmon M.D.							
PHYSICIAN'S NAME (Type) ERNEST E. HARMON 9301 Colesville Rd. Silver Spring							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 9/17/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR SEP 17 1957		24b. REGISTRAR'S SIGNATURE J. Nelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

SEP 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809678
3690
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
c. LENGTH OF STAY IN lb 5 1/2 days		d. STREET ADDRESS 4831 36th St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Ellen Mathilde Lyddane		4. DATE OF DEATH Sept 20 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY US Govt. HEW	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Richard Young		14. MOTHER'S MAIDEN NAME Mollie E. Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Eliot R. Young		Address 3252 Aberfoyle Pl. NW.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemiplegia, severe 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 days 544+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 19, 1957 to Sept 20, 1957 , that I last saw the deceased alive on Sept 19, 1957 , and that death occurred at 6:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St NW Wash D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		DATE SIGNED 9.20.57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/23/57	22c. NAME OF CEMETERY OR CREMATORY Oak Hill	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Pamphrey		24a. REC'D BY REGISTRAR DATE 9-21-57	
ADDRESS Washington, D. C.		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JONES		DATE OF DEATH SEP 24 1957	
AGE 45		SEX MALE	
RACE WHITE		BIRTH DATE SEP 13 1912	
PLACE OF BIRTH NEW YORK		CITY OF BIRTH NEW YORK	
MARRIAGE MARRIED		WIFE'S NAME MARY JONES	
EDUCATION HIGH SCHOOL		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		CITY OF DEATH BALTIMORE	
DATE OF DEATH SEP 24 1957		TIME OF DEATH 10:30 AM	
SIGNATURE OF DECEASED JOHN J. JONES		SIGNATURE OF WITNESS MARY JONES	
SIGNATURE OF PHYSICIAN DR. J. J. JONES		SIGNATURE OF CLERK JOHN J. JONES	

BUREAU V. 2

SEP 24 1957

RECEIVED

9691

CERTIFICATE OF DEATH

09679

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melvin Middle Daniel Last Mac Cool				4. DATE OF DEATH Month September Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min.	IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Specialist		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Mac Cool				14. MOTHER'S MAIDEN NAME Celeste Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 193-14-9484 Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Hypertensive cerebral vascular Disease DUE TO cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ↓ DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 14, 1957 , to September 15, 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 6:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/15/57 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE John R. Gill		M.D. John R. Gill, M. D.		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR Bessie M. Thompson		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. 2

SEP 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09680

Reg. Dist. No. 216

9692

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> X2 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban			d. STREET ADDRESS 17816 Aberdeen Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sully Burbank Maize			4. DATE OF DEATH Month Sept. Day 28, Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1870		9. AGE (in years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographic Eng.		10b. KIND OF BUSINESS OR INDUSTRY U.S.G. Survey		11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William R. Maize			14. MOTHER'S MAIDEN NAME Fannie L. Burbank		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 900.0 DUE TO Dislocation & fracture of C 7 with compression of cord 8 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home			
20c. TIME OF INJURY Month, Day, Year 6 a.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Sept. 29, 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/2/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 10-1-57	24b. REGISTRAR'S SIGNATURE Benjamin M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSAUGA STATE DEPARTMENT OF HEALTH - EATONVILLE, ILL.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

1967 5 OCT

RECEIVED

9693

CERTIFICATE OF DEATH

09681

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>				c. LENGTH OF STAY IN 1b <u>Approx 2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARYLANDER REST HOME</u>				d. STREET ADDRESS <u>Washington 47X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>ELEANOR</u> Middle <u>LOUISE</u> Last <u>MALENFANT</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY J. BULLMAN</u>				14. MOTHER'S MAIDEN NAME <u>Caroline C Prasse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>WW-I</u>		17. INFORMANT <u>By Deceased - Prior Arrangements.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum - generalized metastases</u> 154X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 21, 1957</u> , to <u>Sept. 4, 1957</u> , that I last saw the deceased alive on <u>August 30, 1957</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.				ADDRESS (Street, city or town, state) <u>Homersburg, Md</u> DATE SIGNED <u>9/4/57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES P. KERR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>				ADDRESS <u>2224-Wis Ave DC</u>		24a. REC'D BY REGISTRAR <u>Benjie M Thompson</u>	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9694 CERTIFICATE OF DEATH

09682

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3903 Jeffry Street</u>		d. STREET ADDRESS <u>3903 Jeffry Street</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Marbaker</u>		4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Marbaker</u>		14. MOTHER'S MAIDEN NAME <u>Almeda Wage</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>299-22-1276</u>	
17. INFORMANT <u>Vera Marbaker</u>		Address <u>3903 Jeffry St. Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of sigmoid with metastases</u> DUE TO (b) <u>153X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>153X</u> DUE TO (b) <u>153X</u> DUE TO (c) <u>153X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>23 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1957</u> , 19 <u>57</u> , to <u>September</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 8</u> , 19 <u>57</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D.		ADDRESS (Street, city or town, state) <u>6480 New Hampshire Avenue</u>	
PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>		DATE SIGNED <u>Sept. 8, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral Sept. 12, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>St. Philip's Church Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>SEP 10 1957</u>	
ADDRESS <u>8434 Silver Spring Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Frances L. Kelly</u>	

UREAU V. S.

SEP 10 1957

RECEIVED

9695

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darby 75X-3			
f. STREET ADDRESS 15 North 10th Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Leon MARTIN				4. DATE OF DEATH Month Day Year September 27 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 February 1935	
9. AGE (In years lost birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Soloman C. MARTIN				14. MOTHER'S MAIDEN NAME Florence Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Currently				16. SOCIAL SECURITY NO. 162-28-2838		17. INFORMANT (Mother) Mrs. Florence Jackson (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor, type undetermined 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Sept. , 19 57 , to 27 Sept. , 19 57 , that I last saw the deceased alive on 27 Sept. , 19 57 , and that death occurred at 4:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-28-57							
ACTUAL SIGNATURE John W. Troy				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) John W. TROY, LCDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-57		22c. NAME OF CEMETERY OR CREMATORY Union Hill Cemetery		22d. LOCATION (City, town, or county) (State) Kennett Square Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Snowden Funeral Home, 246 N.Wash.Ave., Rockville,				24a. REC'D BY REGISTRAR DATE 9-28-57		24b. REGISTRAR'S SIGNATURE Mary E. Farrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9607

CERTIFICATE OF DEATH

09684
Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colley Park 1614.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Witch. Sanitarium</u>				d. STREET ADDRESS <u>4500 Beechwood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>KAREN L.</u> Last <u>McCRARY</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/17</u>		9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>5</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Vernon F. McCrary</u>				14. MOTHER'S MAIDEN NAME <u>Helen Horney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>V.E. McCrary, (same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity, cerebral vascular defect</u> DUE TO (c) <u>prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/13/57</u> , 19 <u>57</u> , to <u>9/18/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/18/57</u> , 19 <u>57</u> , and that death occurred at <u>8:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marvin I. Mones</u>				ADDRESS (Street, city or town, state) <u>927 Pershing Dr. SILVER SPRING, MD</u>		DATE SIGNED <u>9/18/57</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN I. MONES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery Prince Georges Co., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carraway Rd W.D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. William R. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
9696 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9685
Cerebrovascular accident CERTIFICATE OF DEATH
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>1610 Monroe St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Edith M. Gregor</u> Middle <u>Gregor</u> Last		4. DATE OF DEATH <u>Sept. 7</u> 19 <u>57</u> Month <u>7</u> Day <u>7</u> Year <u>1957</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30-1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Kirwin-Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Lee Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Amada Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>535-01-7322</u>		17. INFORMANT <u>Hospital Records and Daug & Son</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>Yes.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>9</u> Day <u>7</u> Year <u>1957</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/9</u> , 19 <u>57</u> , to <u>9/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Ligon</u>		M.D. <u>Sandy Sperry</u>		ADDRESS (Street, city or town, state) <u>—</u>		DATE SIGNED <u>9/7/57</u>	
PHYSICIAN'S NAME (Type) <u>C. H. LIGON.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Al Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>9-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>	

BUREAU V. S.

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09686

9697

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Key Biscayne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 796 Glenridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Larry Middle Jerome Last McNally		4. DATE OF DEATH Month September Day 6 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1947	9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 9 Days 6 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME Jerome W. McNally		14. MOTHER'S MAIDEN NAME Marjorie Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute aortic insufficiency, operative 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular septal defect and pulmonic stenosis DUE TO (c) Congenital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from September 3, 19 57 , to September 6, 19 57 , that I last saw the deceased alive on September 6, 19 57 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE James A. McFarland		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 9/6/57	
PHYSICIAN'S NAME (Type) JAMES A. MC FARLAND, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
				22d. LOCATION (City, town, or county) Miami Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bowler's Son 1756 Pennsylvania Ave NW, Washington, DC					
24a. REC'D BY REGISTRAR DATE 9-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
JAMES H. HARRIS		Male		30		1924		Baltimore, Md.		Baltimore, Md.		Heart Disease		1954		10:00 AM		Home		J. H. HARRIS		J. H. HARRIS	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Signature of Physician		Signature of Registrar	
None		High School		Married		None		None		None		None		None		None		None		J. H. HARRIS		J. H. HARRIS	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
1954		10:00 AM		Home		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU & F

SEP 13 1954

RECEIVED

9618

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 38 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56 d. STREET ADDRESS 10213 Georgia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle (M.M.N.) Last Meyer		4. DATE OF DEATH Month Sept. Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Jacob Martin Meyer		14. MOTHER'S MAIDEN NAME Salomi Sexaur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Hospital Records.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Rectal abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of end to end bowel anastomosis DUE TO (c) Carcinoma of rectum		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 wks 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **July 30, 1957**, to **Sept 7, 1957**, that I last saw the deceased alive on **Sept 6, 1957**, and that death occurred at **12:30 A.M.**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **8700 Colesville Rd, Silver Spring Md**

DATE SIGNED **9/9/57**

ACTUAL SIGNATURE **W.W. Eastman**

PHYSICIAN'S NAME (Type) **W.W. EASTMAN**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Cemetery	22d. LOCATION (City, town, or county) (State) Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		24a. REC'D BY REGISTRAR 9/9/57	24b. REGISTRAR'S SIGNATURE J. Wilson Dodel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9698

CERTIFICATE OF DEATH

Reg. Dist. No.

2-16

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton <i>16 X 2.2</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month September Day 3 Year 57			
3. NAME OF DECEASED (Type or print) First Dorothy Middle Louise Last Miller		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 6, 1937		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 6 Days 4 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Card Punch Operator		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry F. Miller				14. MOTHER'S MAIDEN NAME Martha I. Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Leukemia, acute, lymphocytic DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 days 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1957 to September 3, 1957 , that I last saw the deceased alive on September 3, 1957 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin E. Liebling				DATE SIGNED 9/3/57			
PHYSICIAN'S NAME (Type) Martin E. Liebling, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-57		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Clinton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				24a. REC'D BY REGISTRAR SEP 5 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9639

Item 2 See: Birth Cert. et
CERTIFICATE OF DEATH

Reg. Dist. No.

2VB

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant Boy</u> Middle <u>Minchin</u> Last <u>Minchin</u>				4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 10, 1957</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Kelvin Lennard Minchin</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Joan Lonergan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-10-1957</u> to <u>9-11-1957</u> that I last saw the deceased alive on <u>9-10-1957</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washes San. Hosp.</u> DATE SIGNED <u>Ruth Standard</u>							
ACTUAL SIGNATURE <u>Ruth Standard</u> M.D. <u>Washes San. Hosp.</u>							
PHYSICIAN'S NAME (Type) <u>Ruth Standard</u> <u>Takoma Park Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hane, M.D.</u> ADDRESS <u>Wash. San. & Hosp.</u>				24a. REC'D BY REGISTRAR <u>9/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. M. Doll</u>	

2075222XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MEDICAL HISTORY		12. HISTORY OF PRESENT ILLNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JURY	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF CORONER	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF TOWNSHIP CLERK	
25. SIGNATURE OF VILLAGE CLERK		26. SIGNATURE OF POSTMASTER		27. SIGNATURE OF SCHOOL SUPERVISOR	
28. SIGNATURE OF CHURCH CLERK		29. SIGNATURE OF MINISTERS		30. SIGNATURE OF RABBIS	
31. SIGNATURE OF OTHER CLERGY		32. SIGNATURE OF OTHER OFFICIALS		33. SIGNATURE OF OTHER PERSONS	
34. SIGNATURE OF OTHER PERSONS		35. SIGNATURE OF OTHER PERSONS		36. SIGNATURE OF OTHER PERSONS	
37. SIGNATURE OF OTHER PERSONS		38. SIGNATURE OF OTHER PERSONS		39. SIGNATURE OF OTHER PERSONS	
40. SIGNATURE OF OTHER PERSONS		41. SIGNATURE OF OTHER PERSONS		42. SIGNATURE OF OTHER PERSONS	
43. SIGNATURE OF OTHER PERSONS		44. SIGNATURE OF OTHER PERSONS		45. SIGNATURE OF OTHER PERSONS	
46. SIGNATURE OF OTHER PERSONS		47. SIGNATURE OF OTHER PERSONS		48. SIGNATURE OF OTHER PERSONS	
49. SIGNATURE OF OTHER PERSONS		50. SIGNATURE OF OTHER PERSONS		51. SIGNATURE OF OTHER PERSONS	
52. SIGNATURE OF OTHER PERSONS		53. SIGNATURE OF OTHER PERSONS		54. SIGNATURE OF OTHER PERSONS	
55. SIGNATURE OF OTHER PERSONS		56. SIGNATURE OF OTHER PERSONS		57. SIGNATURE OF OTHER PERSONS	
58. SIGNATURE OF OTHER PERSONS		59. SIGNATURE OF OTHER PERSONS		60. SIGNATURE OF OTHER PERSONS	
61. SIGNATURE OF OTHER PERSONS		62. SIGNATURE OF OTHER PERSONS		63. SIGNATURE OF OTHER PERSONS	
64. SIGNATURE OF OTHER PERSONS		65. SIGNATURE OF OTHER PERSONS		66. SIGNATURE OF OTHER PERSONS	
67. SIGNATURE OF OTHER PERSONS		68. SIGNATURE OF OTHER PERSONS		69. SIGNATURE OF OTHER PERSONS	
70. SIGNATURE OF OTHER PERSONS		71. SIGNATURE OF OTHER PERSONS		72. SIGNATURE OF OTHER PERSONS	
73. SIGNATURE OF OTHER PERSONS		74. SIGNATURE OF OTHER PERSONS		75. SIGNATURE OF OTHER PERSONS	
76. SIGNATURE OF OTHER PERSONS		77. SIGNATURE OF OTHER PERSONS		78. SIGNATURE OF OTHER PERSONS	
79. SIGNATURE OF OTHER PERSONS		80. SIGNATURE OF OTHER PERSONS		81. SIGNATURE OF OTHER PERSONS	
82. SIGNATURE OF OTHER PERSONS		83. SIGNATURE OF OTHER PERSONS		84. SIGNATURE OF OTHER PERSONS	
85. SIGNATURE OF OTHER PERSONS		86. SIGNATURE OF OTHER PERSONS		87. SIGNATURE OF OTHER PERSONS	
88. SIGNATURE OF OTHER PERSONS		89. SIGNATURE OF OTHER PERSONS		90. SIGNATURE OF OTHER PERSONS	
91. SIGNATURE OF OTHER PERSONS		92. SIGNATURE OF OTHER PERSONS		93. SIGNATURE OF OTHER PERSONS	
94. SIGNATURE OF OTHER PERSONS		95. SIGNATURE OF OTHER PERSONS		96. SIGNATURE OF OTHER PERSONS	
97. SIGNATURE OF OTHER PERSONS		98. SIGNATURE OF OTHER PERSONS		99. SIGNATURE OF OTHER PERSONS	
100. SIGNATURE OF OTHER PERSONS		101. SIGNATURE OF OTHER PERSONS		102. SIGNATURE OF OTHER PERSONS	

RECEIVED
SEP 18 1957
BUREAU V. S.

9699

CERTIFICATE OF DEATH

09699

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montg.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodacres Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Woodacres Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6011 Woodacre Drive</u>		d. STREET ADDRESS <u>6011 Woodacre Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>C.</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 Aug 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't - Bur. of Ships</u>	
11. BIRTHPLACE (State or foreign country) <u>York County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sidney John Moore</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Elizabeth A. Moore</u>		Address <u>Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Previous myocardial infarctions (3)</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 Sept</u> , 19 <u>57</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave Bethesda Md</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D.		PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR M.D</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>10/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Penninsula Mem. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>	24b. REGISTRAR'S SIGNATURE <u></u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1957

RECEIVED

09691

CERTIFICATE OF DEATH

Reg. Dist. No.

216

9700

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 8329 Draper Lane			
3. NAME OF DECEASED (Type or print) First Pearl Middle Catherine Last Moore				4. DATE OF DEATH Month September Day 7 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August, 1896		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Rowlette				14. MOTHER'S MAIDEN NAME Eliza Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14, 1957 , to September 7, 1957 , that I last saw the deceased alive on September 7, 1957 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/7/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Robert Lester		M.D. The Clinical Center		NATIONAL INSTITUTES OF HEALTH		Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/10/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Pk. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR SEP 11 1957	
				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH 12-1-31		6. PLACE OF BIRTH Jackson, Tennessee	
7. DATE OF DEATH 4-4-68		8. PLACE OF DEATH Ft. Belvoir, Alaska		9. CAUSE OF DEATH Multiple Myeloma		10. MANNER OF DEATH Natural		11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	

Multiple Myeloma

4-4-68

13. I, the undersigned, being a duly qualified physician, certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		14. I, the undersigned, being a duly qualified registrar, certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.	
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BUREAU V. S.

SEP 11 1967

RECEIVED

[Handwritten signature and date: 4-11-68]

9701

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5911 Onondago Road				d. STREET ADDRESS 5911 Onondago Road			
3. NAME OF DECEASED (Type or print) KATHERINE MORROW				4. DATE OF DEATH Sept. 8, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 11 Days 25		IF UNDER 24 HRS. Hours 11 Min. 25			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME O. H. Waddle				14. MOTHER'S MAIDEN NAME Hale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs Edwinna Salladay-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days Arteriosclerotic Heart Disease Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 10 days Arteriosclerotic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1952 to Sept 1957 , that I last saw the deceased alive on Sept 7, 1957 , and that death occurred at 7 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I. Donovan M.D.				DATE SIGNED 9/9/57			
PHYSICIAN'S NAME (Type) Leo I. Donovan-8016 Old Georgetown Rd., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Frankford Cemetery		22d. LOCATION (City, town, or county) (State) Frankfort, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 9-9-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Berkley

5911 Quincey Road

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BUREAU V. S.

SEP 11 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9618

CERTIFICATE OF DEATH

09693

213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>26 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Fayette Street</u>				d. STREET ADDRESS <u>15 Fayette St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH ALBERT MOULDEN</u>				4. DATE OF DEATH Month Day Year <u>Sept. 12, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10 12</u>		IF UNDER 24 HRS. <u>10 12</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>			
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Joseph Olive Moulden</u>				14. MOTHER'S MAIDEN NAME <u>Annie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-26-6284</u>		17. INFORMANT <u>Wife</u> <u>Frances C. Moulden</u>		Address <u>15 Fayette St. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GASTROINTESTINAL Bleeding</u> DUE TO (c) <u>PORTAL CIRRHOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 9, 1957</u> to <u>Sept. 13, 1957</u> , that I last saw the deceased alive on <u>12 Sept. 1957</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon S. Rosenberg</u> M.D.				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave.</u>			
DATE SIGNED <u>13 Sept 1957</u>							
PHYSICIAN'S NAME (Type) <u>GORDON S. ROSENBERGER</u>				<u>GA H. Rosenberg, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey,</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Laurel H. Hargrove</u>							

BUREAU V. S.

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9702

CERTIFICATE OF DEATH

Reg. Dist. No.

096846

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 53 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1511 Van Buren Street, N.W.			
3. NAME OF DECEASED (Type or print) First Yetta Middle Rosalind Last Neviaser				4. DATE OF DEATH Month September Day 20 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1908	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Merchandise		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Halpern				14. MOTHER'S MAIDEN NAME Sarah Kallman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast & metastases DUE TO (c) Sys. INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 1957 , to September 20, 1957 , that I last saw the deceased alive on September 20, 1957 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Allen D. Doornik M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/22/57		22c. NAME OF CEMETERY OR CREMATORY ELESAVETGRAD		22d. LOCATION (City, town, or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE D. Danyausky & Sons ADDRESS 3501-14th St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE SEP 25 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
The Christian Center, Bethesda, Md.		Male		45		1911		Maryland		Teacher	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		MEDICAL ATTENDANCE	
September 20, 1957		Bethesda, Md.		Heart Disease		Natural		Several days		Physician	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 SEP 25 1957
 BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9703

CERTIFICATE OF DEATH

09695217

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Rhode Island</u> b. COUNTY <u>Providence</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>13 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>67 Mitchell St</u>			
3. NAME OF DECEASED (Type or print) <u>Lula Hazard Olsen</u>				4. DATE OF DEATH <u>Sept. 13 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6 - 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Providence - R.I.</u>	
13. FATHER'S NAME <u>William L. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Hazard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Hospital Records & Son</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>422.1</u> DUE TO <u>Myocarditis, Smudged</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH. <u>10 min</u> <u>3 yrs</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-18</u> , 19 <u>57</u> to <u>8-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-3</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.W. Bird</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>				DATE SIGNED <u>9/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cranston, Rhode Island</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md</u>				24a. REC'D BY REGISTRAR <u>SEP 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude Lanley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

PLACE OF BIRTH COUNTY STATE		DATE OF BIRTH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE NEGRO OTHER	
MARRIAGE SINGLE MARRIED DIVORCED		OCCUPATION TRADE PROFESSION SERVICE	
PLACE OF DEATH HOME HOSPITAL OTHER		CAUSE OF DEATH DISEASE INJURY OTHER	
DATE OF DEATH MONTH DAY YEAR		TIME OF DEATH HOUR MINUTE	
SIGNATURE OF DECEASED NAME ADDRESS		SIGNATURE OF WITNESS NAME ADDRESS	
SIGNATURE OF PHYSICIAN NAME ADDRESS		SIGNATURE OF CORONER NAME ADDRESS	

BUREAU V. 3

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G220 9-20-57 et

09696

9704

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville				c. LENGTH OF STAY IN 1b 86 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville X				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Clinton Last Orme				4. DATE OF DEATH Month Sept Day 10 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 Sept 21-1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter (General repairs)				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Allen Orme				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr Elmer Orme, Dickerson, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Renal Disease - Mild						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Feb , 19 50 to 10 Sept. , 19 57 , that I last saw the deceased alive on 9 Sept. , 19 57 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		M.D.		ADDRESS (Street, city or town, state) Beallsville, Md			
PHYSICIAN'S NAME (Type) Gordon M. Smith		DATE SIGNED 11 Sept 57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 13-57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hill		ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE 9/13/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

BUREAU V. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809697

9705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen.				d. STREET ADDRESS 365 Hillcrest Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Harry Barton Paschall				4. DATE OF DEATH Sept. 24, 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/97	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managing Editor				10b. KIND OF BUSINESS OR INDUSTRY Strength & Health Magazine		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Frank Paschall				14. MOTHER'S MAIDEN NAME Cynthia Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 288-03-7536		17. INFORMANT Address Mrs. Tony D. Vittorio, 4285 Lawnview Drive Columbus, Ohio			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p> </div> <div style="width: 35%;"> <p>ALL BETWEEN ONSET AND DEATH sudden</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) TRANS. & BURIAL				22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Ashley Cemetery	
				22d. LOCATION (City, town, or county) Ashley, Ohio		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR SEP 27 1957	
				24b. REGISTRAR'S SIGNATURE Gertrude Lawley			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 27 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12-10-57
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
BALTIMORE

DECEASED

DATE

10-10-57

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

9726

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 14 Hr. 45 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1126 17th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carl Middle Atkinson Last PIERSON, Jr.				4. DATE OF DEATH Month September Day 19 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Dec. 1928	9. AGE (In years last birthday) 26 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carl Atkinson PIERSON, Sr.				14. MOTHER'S MAIDEN NAME Louise PRATHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Currently		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? Intracerebral Vas. Malformation DUE TO (c) or Aneurysm of Cereb.						INTERVAL BETWEEN ONSET AND DEATH 18 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 18 Sept. , 19 57 , to 19 Sept. , 19 57 , that I last saw the deceased alive on 19 Sept. , 19 57 , and that death occurred at 4:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Morris H. Lampert				M.D. U.S. Naval Hospital, Bethesda, Maryland			
PHYSICIAN'S NAME (Type) Morris H. Lampert, LT, MC, USNR				U.S. Naval Hospital, Bethesda, Md. 9-19-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-57		22c. NAME OF CEMETERY OR CREMATORY Riverdale Cemetery		22d. LOCATION (City, town, or county) (State) Columbus, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 1557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 9-19-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9707

CERTIFICATE OF DEATH

09699

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Nursing Home				d. STREET ADDRESS 1021 Ruatan St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ESTHER First M. Middle PLYER Last		4. DATE OF DEATH September 4 Month 1957 Day Year					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Garfinckels		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Plyer				14. MOTHER'S MAIDEN NAME Moffatt Anna L. XXXXXXXX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-07-0766		17. INFORMANT Arrington, Va. Mrs. T.B. Marmaduke, 1314 Abington St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 13 , 19 56 , to September 4 , 19 57 , that I last saw the deceased alive on September 4 , 19 57 , and that death occurred at 4:30 P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Henry M. Gowden M.D. 5206 Norway Dr.				September 11, 1957			
PHYSICIAN'S NAME (Type) HENRY M. GOWDEN				Chen Chao, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 9/10/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

SEP 13 1957

RECEIVED

9798

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 35 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon 83x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Box 183		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Janet Middle Frances Last Powell			4. DATE OF DEATH Month September Day 15 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1943	9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Arthur T. Powell			14. MOTHER'S MAIDEN NAME Pauline M. Cornell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral & Tricuspid Stenosis (c) Atrial Septal Defect (Pierced) & Left Mitral INTERVAL BETWEEN ONSET AND DEATH 12 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from August 11, 1957 to September 15, 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Carlos R. Lombardo M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 9/16/57	
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
Removal & Burial - Sept. 18, 1957	Sept. 18, 1957	Chestnut Grove Cemetery	Herndon, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE J. Berkeley Green		ADDRESS Herndon, Va.		24a. RECEIVED BY REGISTRAR DATE 9-16-57	24b. REGISTRAR'S SIGNATURE Bessie M. Kumpson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2708

1957

SEP 18 1957

RECEIVED

SEP 18 1957

BUREAU V. 2

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH 1912		6. PLACE OF BIRTH New York	
7. DECEASED AT New York		8. PLACE OF DEATH New York		9. DATE OF DEATH September 15, 1957		10. TIME OF DEATH 10:30 AM		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED James H. Brown		14. SIGNATURE OF WITNESS John Doe		15. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Brown		16. SIGNATURE OF DECEASED'S PHYSICIAN Dr. Smith		17. SIGNATURE OF DECEASED'S MINISTER Rev. Jones		18. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe	
19. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe		20. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe		21. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe		22. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe		23. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe		24. SIGNATURE OF DECEASED'S BURIAL OFFICER John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09701
9799
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 517 West "B" Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nellie Middle Jane Last Powers				4. DATE OF DEATH Month September Day 15 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1890	
9. AGE (In years last birthday) yrs. 67		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles McLaughlin				14. MOTHER'S MAIDEN NAME Malinda Sutton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis - Type? 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from September 9, 1957 , to September 15 1957 , that I last saw the deceased alive on September 15, 1957 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Leon G. Smith M.D. The Clinical Center PHYSICIAN'S NAME (Type) LEON G. Smith National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 18 57		22c. NAME OF CEMETERY OR CREMATORY Verona Va.		22d. LOCATION (City, town, or county) (State) Verona Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E R Turtle Bros. ADDRESS Brunswick				24. REGISTRAR'S SIGNATURE Bessie Thompson			

ET



BUREAU V. 8

9710

CERTIFICATE OF DEATH

09702

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 16 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3212 Newark St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Howe Middle PRICE Last PRICE		4. DATE OF DEATH Month September Day 14 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Jan. 1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Jearad HOWE		14. MOTHER'S MAIDEN NAME Eleanor E. HARWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, left middle cerebral artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, cerebral DUE TO (c) 4 YRS.		INTERVAL BETWEEN ONSET AND DEATH 3 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington, D.C.	
20f. (City or town) Washington, D.C.		(County) District of Columbia		(State) District of Columbia	
21. I certify that I attended the deceased from 29 Aug. 19 57 , to 14 Sept. 19 57 , that I last saw the deceased alive on 13 Sept. 19 57 , and that death occurred at 1:40 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-14-57 ACTUAL SIGNATURE W.B. Ingram M.D. PHYSICIAN'S NAME (Type) W. B. INGRAM, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-16-57		22c. NAME OF CEMETERY OR CREMATOR Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.		(State) District of Columbia			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. GAWLER'S & Sons ADDRESS 1756 Penn. Ave., N.W. Wash.D.C.		24a. REC'D BY REGISTRAR 9-14-57		24b. REGISTRAR'S SIGNATURE Mary E. Pamel	

VS A15 (4)
15M 9/55

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. SIGNATURE OF REGISTRAR</p>		<p>10. SIGNATURE OF WITNESSES</p>	
<p>11. PLACE OF DEATH</p>		<p>12. DATE OF DEATH</p>		<p>13. TIME OF DEATH</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF PHYSICIAN</p>		<p>17. SIGNATURE OF MORTUARY EXAMINER</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>		<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CEMETERY</p>	

BUREAU V. S.

SEP 17 1957

RECEIVED

9711

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3033 16th Street, N. W.			
3. NAME OF DECEASED (Type or print) First Roy Middle Warren Last Price, Jr.				4. DATE OF DEATH Month September Day 30 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1925		9. AGE (In years lost birthday) 31 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker			10b. KIND OF BUSINESS OR INDUSTRY Social Service		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Roy W. Price, Sr.				14. MOTHER'S MAIDEN NAME Eva Palazzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 047-14-4144		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CONGESTIVE HEART FAILURE, AZOTEMIA DUE TO (c) ESSENTIAL HYPERTENSION						INTERVAL BETWEEN ONSET AND DEATH 4 YEARS 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4 , 19 57 , to September 30 , 19 57 , that I last saw the deceased alive on September 30 , 19 57 , and that death occurred at 6:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/1/57							
ACTUAL SIGNATURE Louis Gillespie, Jr.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Louis Gillespie, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-2-57		22c. NAME OF CEMETERY OR CREMATORY Lees' Crematorium		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				24. READ BY REGISTRAR 0013 1957			
ADDRESS Washington D.C.				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MANHATTAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

NOV 8 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; deceased before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>6 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring '56</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>PROST</u> Last <u>PROST</u>		4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-83</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pipe fitter.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Theodore PROST</u>		14. MOTHER'S MAIDEN NAME <u>Mary Borkman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>205-01-3081</u>	
17. INFORMANT <u>Old Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Sept.</u> , 19 <u>57</u> , to <u>21 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave. Silver Spring Md.</u> DATE SIGNED <u>9-21-57</u> ACTUAL SIGNATURE <u>Morris Perry</u> PHYSICIAN'S NAME (Type) <u>Morris Perry</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Collins</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 1957</u>	
ADDRESS <u>3821 14th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>John Nelson</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

SEP 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 could be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9611

CERTIFICATE OF DEATH

09705-1/17

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tahoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Tahoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>7110 Scyanon Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>R</u> Last <u>PULLHAM</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-11</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman</u>	
11. BIRTHPLACE (State or foreign country) <u>Remington Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Pullham</u>		14. MOTHER'S MAIDEN NAME <u>Cassie Mae Spicer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret E Pullham</u> Address <u>7110 Scyanon Ave Tahoma Park</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, ACUTE</u> DUE TO <u>RIGHT HEART FAILURE AND CORONARY INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8/23/57</u> (c) <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5-</u> 19 <u>57</u> , to <u>9-20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9-16-</u> 19 <u>57</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. A. Hillman</u> M.D.		DATE SIGNED <u>Samuel A. Hillman, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>S. A. HILLMAN</u>		<u>249 Missouri Ave., N.W.</u> <u>Washington 11, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM</u>		22d. LOCATION (City, town, or county) (State) <u>KYATTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u> ADDRESS <u>4812 Hia Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>		24c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Right Heart Failure and Coronary
 Ischemia
 Acute Coronary Thrombosis
 MURDER

SEP 23 1957
 BUREAU V. S.

RECEIVED

2 A. Hillman
 J. C. Hillman
 9-10-57

10-12-57
 21 21 21

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Cedar Grove				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1, Gaithersburg				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Lavinia Last Purdum				4. DATE OF DEATH Month Sept. Day 7 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1872	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 		11. IF UNDER 24 HRS. Months Days Hours Min. 		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Frederick Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard Murdock				14. MOTHER'S MAIDEN NAME Mary Medairy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT LeRoy Purdum, Gaithersburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pathologic arteriosclerosis cardiovascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1948 to Sept. 7, 1957 that I last saw the deceased alive on August 30, 1957 , and that death occurred at 12 noon from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Kern M.D.				ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 9/8/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Upper Seneca		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Moleworth ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR DATE Sept 9/57		24b. REGISTRAR'S SIGNATURE Della W. Burdette	

CERTIFICATE OF DEATH

THIS

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
SEP 17 1957
BUREAU V. S.

09707

MARYLAND STATE DEPARTMENT OF HEALTH

9713

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH - COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Washington, D.C. COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Kensington		CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kensington Gardens Sanitarium		STREET ADDRESS 2434 - 39th St NW	
3. NAME OF DECEASED (Type or Print) Case	(First) B	(Last) Rafter	4. DATE OF DEATH (Month) 9 (Day) 15 (Year) 1957
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan 21, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Scott Rafter		14. MOTHER'S MAIDEN NAME Mary Elizabeth Connell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Wife Mrs Case B Rafter			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

350x Immediate cause	(a) Terminal pneumonia	18 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Parkinson's disease	10 years
493x (c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) None	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **fall** 19**34**, to **Sept.** 18th 19**57**, that I last saw the deceasedalive on **9/18/57**, 19**57**, and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.SIGNATURE **Frank L. Williams M.D.** ADDRESS **2731 Conn. Ave. NW Washington 9-18-57**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 9/20/57	NAME OF CEMETERY OR CREMATORY Arlington National	LOCATION (City, town, or county) Arlington, Virginia	(State) VA
DATE REC'D BY LOCAL REG. 9/26/57	REGISTRAR'S SIGNATURE Frances L. ...	FUNERAL DIRECTOR Joseph ...		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. H.

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9714

CERTIFICATE OF DEATH

09708

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				d. STREET ADDRESS <u>3601 Chesapeake St., N. W.</u>			
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>MARGARET REED</u> Middle <u>REED</u> Last				4. DATE OF DEATH <u>SEPT 15 1957</u> Month <u>15</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 6, 1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>August Koenecke</u>				14. MOTHER'S MAIDEN NAME <u>Fredericka ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert V. Russell</u> Address <u>EM 3-2121</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IMPACTED FRACTURE, LEFT HIP</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug 30, 1957</u> to <u>Sept 15, 1957</u> that I last saw the deceased alive on <u>SEPT 15 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert T. Thibault</u>				ADDRESS (Street, city or town, state) <u>10609 CONCORD ST</u> DATE SIGNED <u>9-15-57</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBAUT</u>				CITY OR TOWN <u>KENSINGTON</u> STATE <u>MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>9-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 9-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		RACE WHITE	
SEX MALE		AGE 50 YEARS	
OCCUPATION LABORER		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF DEATH SEPTEMBER 18, 1957		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF DEATH REGISTRAR (None)		SIGNATURE OF COUNTY CLERK (None)	
SIGNATURE OF HEALTH COMMISSIONER (None)		SIGNATURE OF STATE CLERK (None)	

BUREAU V. 3

SEP 18 1957

RECEIVED

09710 8

9612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MONTGOMERY b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 1805 Good Hope Rd.			
3. NAME OF DECEASED (Type or print) First David Middle John Last Rees				4. DATE OF DEATH Month September Day 30 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-92	9. AGE (In years last birthday) yrs. 65	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Classified--National Security Agency				10b. KIND OF BUSINESS OR INDUSTRY Wales		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME William G. Rees				14. MOTHER'S MAIDEN NAME Sarah Wells			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of bladder DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple abscesses of lung Acute Parotitis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 8-23-57 , 19 57 , to 9-30-57 , 19 57 , that I last saw the deceased alive on 9-29-57 , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur E. Coyne				ADDRESS (Street, city or town, state) Takoma Park Md DATE SIGNED 9-30-57			
PHYSICIAN'S NAME (Type) ARTHUR E. COYNE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md			
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros ADDRESS 1666 Good Hope Rd				24a. REC'D BY REGISTRAR 1	24b. REGISTRAR'S SIGNATURE J. M. L. Dadd		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. PLACE OF BIRTH _____</p>	
<p>10. OCCUPATION _____</p>		<p>11. MARITAL STATUS _____</p>		<p>12. EDUCATION _____</p>	
<p>13. PREVIOUS ILLNESS _____</p>		<p>14. PREVIOUS SURGERY _____</p>		<p>15. PREVIOUS TRAUMA _____</p>	
<p>16. PREVIOUS DRUGS _____</p>		<p>17. PREVIOUS ALCOHOL _____</p>		<p>18. PREVIOUS TOBACCO _____</p>	
<p>19. PREVIOUS RADIATION _____</p>		<p>20. PREVIOUS CHEMOTHERAPY _____</p>		<p>21. PREVIOUS HORMONE THERAPY _____</p>	
<p>22. PREVIOUS TRANSFUSION _____</p>		<p>23. PREVIOUS ORGANS _____</p>		<p>24. PREVIOUS TISSUES _____</p>	
<p>25. PREVIOUS CELLS _____</p>		<p>26. PREVIOUS BLOOD _____</p>		<p>27. PREVIOUS SPERM _____</p>	
<p>28. PREVIOUS OVUM _____</p>		<p>29. PREVIOUS EMBRYO _____</p>		<p>30. PREVIOUS FETUS _____</p>	
<p>31. PREVIOUS INFANT _____</p>		<p>32. PREVIOUS CHILD _____</p>		<p>33. PREVIOUS ADULT _____</p>	
<p>34. PREVIOUS SENIOR _____</p>		<p>35. PREVIOUS ELDERLY _____</p>		<p>36. PREVIOUS VENERABLE _____</p>	
<p>37. PREVIOUS RESPECTABLE _____</p>		<p>38. PREVIOUS HONORABLE _____</p>		<p>39. PREVIOUS NOBLE _____</p>	
<p>40. PREVIOUS DISTINGUISHED _____</p>		<p>41. PREVIOUS EMINENT _____</p>		<p>42. PREVIOUS PROMINENT _____</p>	
<p>43. PREVIOUS NOTED _____</p>		<p>44. PREVIOUS FAMOUS _____</p>		<p>45. PREVIOUS CELEBRATED _____</p>	
<p>46. PREVIOUS INFAMOUS _____</p>		<p>47. PREVIOUS NOTORIOUS _____</p>		<p>48. PREVIOUS OBSCURE _____</p>	
<p>49. PREVIOUS UNKNOWN _____</p>		<p>50. PREVIOUS MISCELLANEOUS _____</p>		<p>51. PREVIOUS OTHER _____</p>	

BUREAU K. 3

OCT 1 1957

RECEIVED

9715

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M</u> Last <u>Reeds</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Office Bldg</u>			
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Franklin Reeds</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-28-6308</u>			
17. INFORMANT <u>Ileene Reeds Danowsky</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Cardiac Arrhythmia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic</u> DUE TO (c) <u>Heart disease</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>6 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>10:30</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> 19 <u>52</u> to <u>Sept 7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 7</u> 19 <u>57</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael M Healy</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>8-11-57</u>			
PHYSICIAN'S NAME (Type) <u>MICHAEL M HEALY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>Beenie M Thompson</u> 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK - ALBANY

NAME OF DECEASED <i>John A. Smith</i>		DATE OF BIRTH <i>10-15-1885</i>	PLACE OF BIRTH <i>New York City</i>
RESIDENCE <i>123 Main St., New York City</i>		DATE OF DEATH <i>10-25-1957</i>	PLACE OF DEATH <i>New York City</i>
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	IMMEDIATE CAUSE <i>Myocardial Infarction</i>
MANNER OF DEATH <i>Natural</i>		DATE OF INTERMENT <i>10-27-1957</i>	PLACE OF INTERMENT <i>St. John's Cemetery</i>
SIGNATURE OF DECEASED <i>John A. Smith</i>		SIGNATURE OF WITNESSES <i>John A. Smith, Mary A. Smith</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. A. Smith</i>		SIGNATURE OF CLERK <i>John A. Smith</i>	
SIGNATURE OF JUDGE <i>John A. Smith</i>		SIGNATURE OF NOTARY <i>John A. Smith</i>	

BUREAU V. E.

SEP 16 1957

RECEIVED

9716

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 833 Gist Ave.				d. STREET ADDRESS 833 Gist Ave. 1			
3. NAME OF DECEASED (Type or print) First Middle Last Lemuel Hickie Rinker				4. DATE OF DEATH Month Day Year Sept. 23 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/82	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mt. Jackson, Va.	
13. FATHER'S NAME Lemuel H. Rinker				14. MOTHER'S MAIDEN NAME Mary Ellen Zirkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-0639		17. INFORMANT Address Cora L. Rinker 833 Gist Ave. S.S. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 4, 1957 , to Sept. 23, 1957 , that I last saw the deceased alive on Sept. 22, 1957 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Marion Bausch				ADDRESS (Street, city or town, state) 9241 Cal. Blvd Silver Spring, Md.			
DATE SIGNED 9/23/57							
22a. BURIAL, CREMATION, or other disposal (Specify) buried		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 25 1957	
				24b. REGISTRAR'S SIGNATURE Francis Patten			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "Jan 15, 1910"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE [Faint text, possibly "June 1, 1935"]</p>	
<p>9. NAME OF DECEASED'S MOTHER [Faint text, possibly "Mary Jane Doe"]</p>		<p>10. NAME OF DECEASED'S FATHER [Faint text, possibly "John Doe"]</p>	
<p>11. NAME OF DECEASED'S SPOUSE [Faint text, possibly "Jane Doe"]</p>		<p>12. NAME OF DECEASED'S CHILDREN [Faint text, possibly "John Doe Jr., Mary Doe"]</p>	
<p>13. NAME OF DECEASED'S BROTHERS [Faint text, possibly "John Doe Sr., James Doe"]</p>		<p>14. NAME OF DECEASED'S SISTERS [Faint text, possibly "Mary Doe, Elizabeth Doe"]</p>	
<p>15. NAME OF DECEASED'S NEAREST RELATIVE [Faint text, possibly "John Doe Jr."]</p>		<p>16. ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Baltimore, Md"]</p>	
<p>17. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>18. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>19. DATE OF DEATH [Faint text, possibly "Sep 20, 1957"]</p>		<p>20. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>	
<p>21. NAME OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]</p>		<p>22. NAME OF BURIAL PLACE [Faint text, possibly "Greenwood Cemetery"]</p>	
<p>23. NAME OF BURIAL PLACE [Faint text, possibly "Greenwood Cemetery"]</p>		<p>24. NAME OF BURIAL PLACE [Faint text, possibly "Greenwood Cemetery"]</p>	

BUREAU V. 8

SEP 25 1957

RECEIVED

9717

CERTIFICATE OF DEATH

09712

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5406 Seminary Road			
3. NAME OF DECEASED (Type or print) First James Middle Alfred Last Roberts				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1915	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Installer		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Roberts				14. MOTHER'S MAIDEN NAME Myrtle Weakley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-7167		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkins Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. 19	Day. 19	Year. 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26, 1957 , to September 27, 1957 , that I last saw the deceased alive on September 27, 1957 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger Lester				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) Roger Lester				DATE SIGNED 9/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-1-57		22c. NAME OF CEMETERY OR CREMATORY Wash - Nat.	
22d. LOCATION (City, town, or county) (State) Switzland, Md.				23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Wash. DC ADDRESS			
24a. REC'D BY REGISTRAR OCT 2 1957				24b. REGISTRAR'S SIGNATURE Bessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Rev. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL OPINION	
OCTOBER 1, 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE	
10:00		10		00		P		98.6		60	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION		DISEASE OR INJURY		MEDICAL OPINION	
OCTOBER 2, 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO	

RECEIVED
OCT 2 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9718

CERTIFICATE OF DEATH

09713

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>X1 Poolesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Rt 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA Isabelle Robinson</u>				4. DATE OF DEATH Month Day Year <u>Sept 7 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 15, 1887</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poolesville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>yes</u>							
13. FATHER'S NAME <u>Frank Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Pruner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Husband, Charles Robinson, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Auricular fibrillation with mural thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 18, 1957</u> , to <u>Sept 8, 1957</u> , that I last saw the deceased alive on <u>Sept 6, 1957</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. Summitt Ave.</u> DATE SIGNED <u>9A HARRIS BURG, MD.</u>							
ACTUAL SIGNATURE <u>Gordon Rosenberg</u>				PHYSICIAN'S NAME (Type) <u>9A HARRIS BURG, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poolesville,</u>		22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Saunden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jessie Thompson</u>	

BUREAU V. S.

SEP 16 1957

RECEIVED

Polioville,

1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09714
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9719

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12413 Denley Rd</u>			d. STREET ADDRESS <u>12413 Denley Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Nicholas Raymond Roseway SR</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23-1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>stone keeper</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
13. FATHER'S NAME <u>Charles Roseway</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth May</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>N.R. Roseway Jr -</u>			Address <u>Stem # 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>		(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>			ADDRESS <u></u>		
24a. RECEIVED BY REGISTRAR <u>SEP 13 1957</u>			24b. REGISTRAR'S SIGNATURE <u>James Patten</u>		

DATE SIGNED

9-12-57

BUREAU V. S.

SEP 13 1957

RECEIVED

09715

9613

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.		
c. LENGTH OF STAY IN 1b 9 Days			d. STREET ADDRESS 1259 New Hampshire Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jenny Middle Laurence Last Sagen			4. DATE OF DEATH Month Sept. Day 28 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-87		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Norway	
13. FATHER'S NAME Osten Sagen		14. MOTHER'S MAIDEN NAME Louise Siursen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Hospital Records Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 603x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrectomy, left DUE TO (c) Intra-renal hemorrhage.					INTERVAL BETWEEN ONSET AND DEATH few hrs. 15 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent hysterectomy for carcinoma of endometrium					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month 10 Day 3 Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pr. Geo. Co., Maryland	(County) --- (State) ---
21. I certify that I attended the deceased from 18 Sept. 1957 to 28 Sept. 1957 , that I last saw the deceased alive on 27 Sept. 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) --- DATE SIGNED ---					
ACTUAL SIGNATURE A. J. Wilets M.D.					
PHYSICIAN'S NAME (Type) A. J. Wilets					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10/3/1957	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Pr. Geo. Co., Maryland (State) ---	
23. FUNERAL DIRECTOR'S SIGNATURE ---			24a. REC'D BY REGISTRAR --- DATE 10-2-57		
			24b. REGISTRAR'S SIGNATURE J. Wilson Dodd		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 2 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09716

9614

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Blair Rd		d. STREET ADDRESS 7700 BLAIR RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNIE Middle SAKOFSKY Last SAKOFSKY		4. DATE OF DEATH Month 9 - Day 7 - Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 5, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) HONESDALE PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME ELIAS ABRAMS		14. MOTHER'S MAIDEN NAME BERTHA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 190-14-1356	
17. INFORMANT HARRY SAKS-10424 HATHING-ST.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF GALL BLADDER 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-23- , 19 55 , to 9-7- , 19 57 , that I last saw the deceased alive on 9-6-57 , 19 57 , and that death occurred at 5:03 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome J. Krick		ADDRESS (Street, city or town, state) 2800 Quebec St N.W. DATE SIGNED 9-7-57	
PHYSICIAN'S NAME (Type) JEROME J. KRICK			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY TEMPLE ISRAEL CEMETERY	22d. LOCATION (City, town, or county) (State) DUNMORE PA
23. FUNERAL DIRECTOR'S SIGNATURE B. Drangovsky & Sons		24a. REC'D BY REGISTRAR 10/10/57 24b. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS 3501-14 24th Ave.			

BUREAU V. S.

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9720

CERTIFICATE OF DEATH

Item 1c, & Block 21, Film 220 9-13-57 et

09717

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 103 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3807 Benton Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janet Middle Eileen Last Sams		4. DATE OF DEATH Month September Day 9 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1918
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 39	IF UNDER 24 HRS. Days 39 Hours 39 Min. 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Mitchell		14. MOTHER'S MAIDEN NAME Mae Mannion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-28-4884	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anoxia (c) Metastatic Disease in Lung & Pleural Effusion Malignant Melanoma		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1957 to September 9, 1957 that I last saw the deceased alive on September 9, 1957 and that death occurred at 7:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Arthur J. Garceau		DATE SIGNED 9/9/57	
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-11-57	22c. NAME OF CEMETERY OR CREMATORY National Memorial Park	22d. LOCATION (City, town, or county) (State) Falls Church Va
23. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		ADDRESS 4812 Ga Ave NW	
24. REC'D BY REGISTRAR SEP 11 1957		25. REGISTRAR'S SIGNATURE Bessie Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09718213
Reg. Dist. No.

9619

OR STATE
HEALTH DEPT.

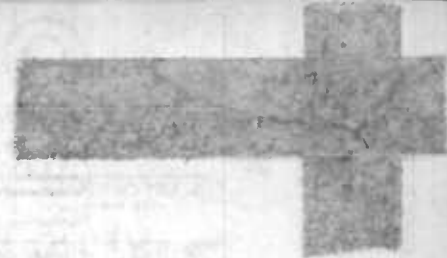
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>907 Grandin Ave</u>			d. STREET ADDRESS <u>1910 Vienna Mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frank Conrad Schneider Sr.</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>John Schneider</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-03-4628A</u>		17. INFORMANT <u>Paul C. Schneider (son)</u> Address <u>301 Potomac St Rockville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 9 1957</u>			24b. REGISTRAR'S SIGNATURE <u>Lawrence Kuyper</u>		

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 9 1957

BUREAU V. S.



9721

CERTIFICATE OF DEATH

09719

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 157 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month September Day 21 Year 57				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH November 10, 1926 9. AGE (In years last birthday) 30 yrs. IF UNDER 1 YEAR: Months 30 Days 30 Hours 30 Min. 30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Buyer				10b. KIND OF BUSINESS OR INDUSTRY Lumber			
11. BIRTHPLACE (State or foreign country) Nebraska				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ernest P. Schroeder				14. MOTHER'S MAIDEN NAME Edyth Skewes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 507-36-9526			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 192X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intactile carcinoma DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days 7 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 17, 1957 , to September 21, 1957 , that I last saw the deceased alive on September 21, 1957 , and that death occurred at 2:55p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Allen D. Goodman M.D. M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/22/57			
PHYSICIAN'S NAME (Type) ALLEN D. GOODMAN, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. - Transit		22b. DATE THEREOF 9/22/57		22c. NAME OF CEMETERY OR CREMATORY Imperial		22d. LOCATION (City, town, or county) (State) Chase County, Nebraska	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 9-24-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1957	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	

RECEIVED
 SEP 26 1957
 BUREAU V. S.

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 100-111111-111111
 100-111111-111111

9722

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 73 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 8737 Carroll Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred		First James Middle Serbin Last		4. DATE OF DEATH Month September Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1904	
9. AGE (In years, last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Engineer				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Solomon Serbin				14. MOTHER'S MAIDEN NAME Fanny Bloom			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 111077096		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute duodenal ulcer							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957 , to September 23, 1957 , that I last saw the deceased alive on September 23, 1957 , and that death occurred at 2:15 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Moore M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/23/57			
PHYSICIAN'S NAME (Type) EDWARD W. MOORE, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Va	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501 14th St., N.W.		24a. REC'D BY REGISTRAR SEP 27 1957	
				24b. REGISTRAR'S SIGNATURE Jessie Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

BUREAU V. 3.

SEP 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9723

CERTIFICATE OF DEATH

09721

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1820 Fort Davis Street, S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sylvia</u> Middle <u>Belle</u> Last <u>SESSIONS</u>				4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 Sept. 1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
13. FATHER'S NAME <u>William BOYD</u>				14. MOTHER'S MAIDEN NAME <u>Florence Haley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Sister) Mrs. Leola L. BOYD (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glioblastoma multiforme</u> <u>193x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
21. I certify that I attended the deceased from <u>19 August</u> , 19 <u>57</u> , to <u>14 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>6:40A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-14-57</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John W. Troy</u> PHYSICIAN'S NAME (Type) <u>John W. Troy, LCDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mattingly</u> ADDRESS <u>MATTINGLY, 131 11th St. S.E. Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

BUREAU V. S.

SEP 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09722

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Connecticut</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>46 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1692 Whitney Ave.,</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Arthur SHARP</u>				4. DATE OF DEATH Month Day Year <u>September 3 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 March 1906</u>	
9. AGE (In years lost birthday) yrs. <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Arthur SHARP</u>				14. MOTHER'S MAIDEN NAME <u>Loraine PARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-I and II</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Fredericka SHARP, (Wife) (Same :As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor (Glioma)</u> <u>193x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>15 June</u> , 19 <u>57</u> , to <u>3 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 Aug.</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-3-57</u>							
ACTUAL SIGNATURE <u>W.H. Druckemiller</u> M.D.							
PHYSICIAN'S NAME (Type) <u>W.H. DRUCKEMILLER, CAPT, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington, Natl Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>1551 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09723

9725

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 62 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3910 Ingomar Street, N. W.	
3. NAME OF DECEASED (Type or print) First Wanda Middle Frances Last Shea		4. DATE OF DEATH Month September Day 18 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1914 September 9, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer		10b. KIND OF BUSINESS OR INDUSTRY Publishing	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Milton Hair		14. MOTHER'S MAIDEN NAME Eula Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myeloid Metaplasia DUE TO (c) Polycythemia Vera		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1957 , to September 18, 1957 , that I last saw the deceased alive on September 18, 1957 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles G. Lewallen		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 9/18/57 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) CHARLES G. LEWALLEN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/21/57	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	22d. LOCATION (City, town, or county) (State) Silver Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawlor's Sons, Wash., D. C.		24a. REC'D BY REGISTRAR DATE 9-21-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WILLIAM J. HARRIS

WHITE

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BUREAU V. S.

SEP 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09724
9726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	c. LENGTH OF STAY IN 1b 12 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3930 Washington St.		d. STREET ADDRESS 3930 Washington St.	
3. NAME OF DECEASED (Type or print) Margaret Simpson Sheppard		4. DATE OF DEATH Month Sept 1, 1957 Day 19 Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Mexico		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. P. Simpson		14. MOTHER'S MAIDEN NAME Lillie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sherman Sheppard (husband)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left breast with metastasis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 9/2/57	
22a. BURIAL, CREMATION, or other disposal (Specify) CREMATION		22b. DATE THEREOF 9/2/57	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR 9/5/57		24b. REGISTRAR'S SIGNATURE Francis Potter	

9727

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4121 Woodbine Street</u>	
3. NAME OF DECEASED (Type or print) <u>ERNEST R. SLADE</u>		4. DATE OF DEATH <u>Sept 18 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/96</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR <u>1</u> Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Gloversville, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Albert Parsons Slade</u>		14. MOTHER'S MAIDEN NAME <u>Alice Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Alice Slade</u>		Address <u>4121 Woodbine St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>10 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Sept 18 1957</u> , that I last saw the deceased alive on <u>Sept 18 1957</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash 15 D.C.</u> DATE SIGNED <u>9-18-57</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. N.W. Wash 15 D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Transf</u>		22b. DATE THEREOF <u>9/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ferndale</u>		22d. LOCATION (City, town, or county) (State) <u>Gloversville, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>9-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Robert A. Pumphter - Belasco, 45.		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Sept 23 1957		5. TIME OF DEATH 11:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	
13. SIGNATURE OF NEXT OF KIN [Signature]		14. SIGNATURE OF BURIAL OFFICIAL [Signature]		15. SIGNATURE OF FUNERAL HOME [Signature]	
16. SIGNATURE OF CHURCH OFFICIAL [Signature]		17. SIGNATURE OF CEMETERY OFFICIAL [Signature]		18. SIGNATURE OF OTHER OFFICIAL [Signature]	
19. SIGNATURE OF OTHER OFFICIAL [Signature]		20. SIGNATURE OF OTHER OFFICIAL [Signature]		21. SIGNATURE OF OTHER OFFICIAL [Signature]	
22. SIGNATURE OF OTHER OFFICIAL [Signature]		23. SIGNATURE OF OTHER OFFICIAL [Signature]		24. SIGNATURE OF OTHER OFFICIAL [Signature]	
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37. SIGNATURE OF OTHER OFFICIAL [Signature]		38. SIGNATURE OF OTHER OFFICIAL [Signature]		39. SIGNATURE OF OTHER OFFICIAL [Signature]	
40. SIGNATURE OF OTHER OFFICIAL [Signature]		41. SIGNATURE OF OTHER OFFICIAL [Signature]		42. SIGNATURE OF OTHER OFFICIAL [Signature]	
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52. SIGNATURE OF OTHER OFFICIAL [Signature]		53. SIGNATURE OF OTHER OFFICIAL [Signature]		54. SIGNATURE OF OTHER OFFICIAL [Signature]	
55. SIGNATURE OF OTHER OFFICIAL [Signature]		56. SIGNATURE OF OTHER OFFICIAL [Signature]		57. SIGNATURE OF OTHER OFFICIAL [Signature]	
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61. SIGNATURE OF OTHER OFFICIAL [Signature]		62. SIGNATURE OF OTHER OFFICIAL [Signature]		63. SIGNATURE OF OTHER OFFICIAL [Signature]	
64. SIGNATURE OF OTHER OFFICIAL [Signature]		65. SIGNATURE OF OTHER OFFICIAL [Signature]		66. SIGNATURE OF OTHER OFFICIAL [Signature]	
67. SIGNATURE OF OTHER OFFICIAL [Signature]		68. SIGNATURE OF OTHER OFFICIAL [Signature]		69. SIGNATURE OF OTHER OFFICIAL [Signature]	
70. SIGNATURE OF OTHER OFFICIAL [Signature]		71. SIGNATURE OF OTHER OFFICIAL [Signature]		72. SIGNATURE OF OTHER OFFICIAL [Signature]	
73. SIGNATURE OF OTHER OFFICIAL [Signature]		74. SIGNATURE OF OTHER OFFICIAL [Signature]		75. SIGNATURE OF OTHER OFFICIAL [Signature]	
76. SIGNATURE OF OTHER OFFICIAL [Signature]		77. SIGNATURE OF OTHER OFFICIAL [Signature]		78. SIGNATURE OF OTHER OFFICIAL [Signature]	
79. SIGNATURE OF OTHER OFFICIAL [Signature]		80. SIGNATURE OF OTHER OFFICIAL [Signature]		81. SIGNATURE OF OTHER OFFICIAL [Signature]	
82. SIGNATURE OF OTHER OFFICIAL [Signature]		83. SIGNATURE OF OTHER OFFICIAL [Signature]		84. SIGNATURE OF OTHER OFFICIAL [Signature]	
85. SIGNATURE OF OTHER OFFICIAL [Signature]		86. SIGNATURE OF OTHER OFFICIAL [Signature]		87. SIGNATURE OF OTHER OFFICIAL [Signature]	
88. SIGNATURE OF OTHER OFFICIAL [Signature]		89. SIGNATURE OF OTHER OFFICIAL [Signature]		90. SIGNATURE OF OTHER OFFICIAL [Signature]	
91. SIGNATURE OF OTHER OFFICIAL [Signature]		92. SIGNATURE OF OTHER OFFICIAL [Signature]		93. SIGNATURE OF OTHER OFFICIAL [Signature]	
94. SIGNATURE OF OTHER OFFICIAL [Signature]		95. SIGNATURE OF OTHER OFFICIAL [Signature]		96. SIGNATURE OF OTHER OFFICIAL [Signature]	
97. SIGNATURE OF OTHER OFFICIAL [Signature]		98. SIGNATURE OF OTHER OFFICIAL [Signature]		99. SIGNATURE OF OTHER OFFICIAL [Signature]	
100. SIGNATURE OF OTHER OFFICIAL [Signature]		101. SIGNATURE OF OTHER OFFICIAL [Signature]		102. SIGNATURE OF OTHER OFFICIAL [Signature]	

BUREAU V. S.

SEP 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>225 Dill Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Bernard</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> *** DIVORCED *** <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1886</u>
9. AGE (In years last birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christopher P. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Helen Regina Ely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1215-26-8251</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PURULENT PERITONITIS, Generalized</u> DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF STOMACH</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>72 hr.</u> <u>6 mo.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 12</u> , 19 <u>57</u> , to <u>September 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 14</u> , 19 <u>57</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>9/15/57</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>			
ACTUAL SIGNATURE <u>James L. German, M.D.</u>		PHYSICIAN'S NAME (Type) <u>James L. German, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick- Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		ADDRESS <u>Frederick-Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>Sept 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE OF DEATH		UNDERLYING CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	

RECEIVED
 SEP 20 1957
 BUREAU V. 3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9728

CERTIFICATE OF DEATH

09727

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		13X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS St. John's Manor	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgia Middle Christine Last Snader		4. DATE OF DEATH Month September Day 17 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, 1951
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months 5 Days 17 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earle S. Snader		14. MOTHER'S MAIDEN NAME Patricia Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphoblastic leukemia DUE TO 1 1/2 yrs (c) 2 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 6, 1957 , to September 17, 1957 , that I last saw the deceased alive on September 17, 1957 , and that death occurred at 8:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger Lester		DATE SIGNED 9/17/57	
PHYSICIAN'S NAME (Type) Roger Lester, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons		24a. RECEIVED BY REGISTRAR SEP 20 1957	
ADDRESS 1900 Eutaw Place		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

BURN

SEP 20 1957

RECEIVED

9615

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		d. STREET ADDRESS 5726 1st Street, N.W.	
3. NAME OF DECEASED (Type or print) PAM DEN GKAS First Middle Last SAERASETJA		4. DATE OF DEATH September 7 Month Day Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH - -
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chancellor Embassy of Republic of Indonesia		11. BIRTHPLACE (State or foreign country) Indonesia	
13. FATHER'S NAME unobtainable		14. MOTHER'S MAIDEN NAME unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		17. INFORMANT Embassy Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-operative shock 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RT Nephrolithotomy (Staghorn calculus) DUE TO (c) Staghorn calculus (Pilonid) and suppurative pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/26 , 19 57 , to 9/5 , 19 57 that I last saw the deceased alive on 9/5 , 19 57 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 909 Pershing Drive, Silver Spring, Md. DATE SIGNED Arthur J. Wilets			
ACTUAL SIGNATURE Arthur J. Wilets		M.D. 909 Pershing Drive, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Arthur J. Wilets			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9/10/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,		24a. REC'D BY REGISTRAR SEP 10 1957	24b. REGISTRAR'S SIGNATURE J. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

SEP 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 50 M 0 2 1 VS A15 (4) 15M 9/55 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9729 CERTIFICATE OF DEATH

09729
Reg. Dist. No. *211*

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 66 Hurd Street			
3. NAME OF DECEASED (Type or print) First Frederick Middle August Last Sohm				4. DATE OF DEATH Month September Day 23 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1911	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Assembly		10b. KIND OF BUSINESS OR INDUSTRY Machinery		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian G. Sohm				14. MOTHER'S MAIDEN NAME Julia Koch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 144-07-8093		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cranial (intraventricular) hemorrhage 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Melanoma, metastatic to brain & lungs DUE TO (c) Malignant Melanoma, skin, right mandibular region						INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 16, 1957 , to September 23, 1957 , that I last saw the deceased alive on September 23, 1957 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/23/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Edward W. Moore M.D.				PHYSICIAN'S NAME (Type) EDWARD W. MOORE, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/57		22c. NAME OF CEMETERY OR CREMATORY Locust Hill		22d. LOCATION (City, town, or county) (State) Dover, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 9-26-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death	
John Doe		Male		45		1912		1957		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Physician		High School	
Date of Autopsy		Place of Autopsy		Name of Pathologist		Signature of Physician		Signature of Registrar		Signature of Medical Examiner	
1957		Baltimore, Md.		John Doe		John Doe		John Doe		John Doe	

BUREAU V. 1

SEP 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09730 216
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Mont			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3805 Raymond Street				d. STREET ADDRESS 3805 Raymond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Gardner Last Squires				4. DATE OF DEATH Month September Day 27 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/91	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner-Federal Dept. Ins. Corp.			10b. KIND OF BUSINESS OR INDUSTRY Illinois		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Cyrus Squires			14. MOTHER'S MAIDEN NAME Katherine Gardner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Navy WW # 1		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Edward C. Squires 3805 Raymond St. CC. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John G. Ball				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/1/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.,				24. REC'D BY REGISTRAR SEP 30 1957		24b. REGISTRAR'S SIGNATURE Leslie Thompson	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. Smith		Male		45		Caucasian		10/15/1957		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social History	
Myocardial Infarction		Natural		Carpenter		High School		Married		Nonsmoker	
Medical History		Family History		Previous Illnesses		Surgical History		Drugs		Alcohol	
Hypertension		None		None		None		None		None	
Physical Examination		Vital Signs		Laboratory Tests		X-ray		Autopsy		Remarks	
Normal		Normal		Normal		Normal		Not Performed		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

SEP 30 1957

RECEIVED

9731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1415 Highland Drive				d. STREET ADDRESS 1415-Highland Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Claire Middle Johnson Last Stevens				4. DATE OF DEATH Month Sept Day 19 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1878		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram Johnson				14. MOTHER'S MAIDEN NAME Frances M. Gale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT James M. Stevens		Address Silver Spring, Md. -1415 Highland Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastro Enteritis 572.1 DUE TO Peritonitis (flare up) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 9, 1957 to 9/19, 1957 that I last saw the deceased alive on 9/19, 1957 , and that death occurred at 3:12 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Burns				ADDRESS (Street, city or town, state) 915-19th St. N.W. Wash. D.C.		DATE SIGNED 9/19/57	
PHYSICIAN'S NAME (Type) JAMES T. BURNS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEROF 9/21/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W. Wash				24a. REC'D BY REGISTRAR SEP 24 1957		24b. REGISTRAR'S SIGNATURE Frances Carter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Don't miss it.

071010

BUREAU V. S.

SEP 24 1957

RECEIVED

09732 214

9732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> MONTGOMERY b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>11908 AUGUST DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>JOSEPHINE</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 13, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESS MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>CHARLES COUNTY MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>JAMES M. PROCTOR</u>				14. MOTHER'S MAIDEN NAME <u>IDA BENNEX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>177</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR STANLEY DOUGHERTY</u> Address <u>1908 AUGUST DR SILVER SPRING MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PLURAL EFFUSION - LEFT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>PRIMARY SITE LEFT BREAST</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u> <u>2 YRS</u> <u>5 YRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>1957</u> , that I last saw the deceased alive on <u>SEPT 4</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry W. Stout MD</u> M.D. <u>10011 Georgia Ave</u>				ADDRESS (Street, city or town, state) <u>Silver Spring Md</u> DATE SIGNED <u>9/8/57</u>			
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 10 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Lance Potter</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. ETHNIC ORIGIN</p> <p>13. SOCIAL CLASS</p> <p>14. INCOME</p> <p>15. HEALTH STATUS</p> <p>16. PREVIOUS ILLNESS</p> <p>17. CAUSE OF DEATH</p> <p>18. MANNER OF DEATH</p> <p>19. TIME OF DEATH</p> <p>20. PLACE OF DEATH</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. SIGNATURE OF REGISTRAR</p> <p>23. SIGNATURE OF WITNESSES</p> <p>24. SIGNATURE OF DECEASED</p>		<p>25. DATE OF DEATH</p> <p>26. TIME OF DEATH</p> <p>27. PLACE OF DEATH</p> <p>28. SIGNATURE OF PHYSICIAN</p> <p>29. SIGNATURE OF REGISTRAR</p> <p>30. SIGNATURE OF WITNESSES</p> <p>31. SIGNATURE OF DECEASED</p>
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BUREAU V. S.

SEP 10 1957

RECEIVED

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 78

Item 9 Film 2220 9-17-57 et. seq.

9620

CERTIFICATE OF DEATH

Reg. Dist. No.

09733

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>343 E Montg. Ave</u>				d. STREET ADDRESS <u>343 E. Montg. Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Wm R</u> First Middle Last				4. DATE OF DEATH <u>Sept 8</u> Month Day Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 14-1895</u>	
9. AGE (In years last birthday) <u>61 1/4</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA</u>			
11. BIRTHPLACE (State or foreign country) <u>VA</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Unknown Wm Stream</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lanham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>312-14-3292</u>			
17. INFORMANT <u>Marshall R. Stream</u>				Address <u>1025 Paul Dr. Rockville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis + moderate hypertension</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Sept 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>57</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm A. Linthicum</u> M.D.				ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. Gaithersburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wm A. Linthicum</u>				DATE SIGNED <u>9/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/12/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>			
24a. REC'D BY REGISTRAR <u>9/10/57</u>				24b. REGISTRAR'S SIGNATURE <u>Laurel Kragtop</u>			

SEP 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09734

Reg. Dist. No.

214

9733

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9505 Black Oak Cts.			d. STREET ADDRESS 9505 Black Oak Cts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Bonnie Jeane Sublett			4. DATE OF DEATH Month Sept. Day 22, Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1895		9. AGE (in years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Coveburg, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Bonnie Jean Attreed Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart attacks					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/23/57	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY	
				22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner B. Humphrey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR SEP 24 1957	
				24b. REGISTRAR'S SIGNATURE <i>Frances Patter</i>	

RECEIVED

SEP 24 1957

BUREAU V. 3

9621

CERTIFICATE OF DEATH

09735

Reg. Dist. No. 213

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4108 Great Oak Rd. Manor Club Estates		d. STREET ADDRESS 4108 Great Oak Rd. Manor Club Estates	
3. NAME OF DECEASED (Type or print) First James Middle Eugene Last Sullivan		4. DATE OF DEATH Month September Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Aeronautical Instrument Co.	
11. BIRTHPLACE (State or foreign country) Franklin, New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Sullivan		14. MOTHER'S MAIDEN NAME Alice Welch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 215-36-4942	
17. INFORMANT Dr. James R. Sullivan		Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153x Carcinomatosis DUE TO Leucemia Sympt Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 mos 2 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) L	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/4 , 19 57 , to 9/29 , 19 57 , that I last saw the deceased alive on 9/28 , 19 57 , and that death occurred at 9:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED 9/30/57 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) Jacob W. Bird			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/2/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey		24a. REC'D BY REGISTRAR 10-2-57	24b. REGISTRAR'S SIGNATURE Laurell Kratoch

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9731

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Louise Last Thomas		4. DATE OF DEATH Month September Day 27 Year 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/27
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Kelley		14. MOTHER'S MAIDEN NAME Mary Anna Hodge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493x IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 18+ days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/9/57 to 9/27/57 , 19 57 , that I last saw the deceased alive on 9/27/57 , 19 57 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		DATE SIGNED 9/28/57	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/57	22c. NAME OF CEMETERY OR CREMATORY Sandy Spring	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodden		24a. REC'D BY REGISTRAR Oct 3 1957	24b. REGISTRAR'S SIGNATURE Gertrude Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the funeral director.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. CONNOLLY		45		M		W		JAN 15 1892		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
100 WASHINGTON ST. BOSTON		LABORER		HEART DISEASE		NATURAL		OCT 2 1957		BOSTON	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
JAMES J. CONNOLLY		MARY J. CONNOLLY		8		CATHOLIC		MARRIED		NONE	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CHURCH	
OCT 3 1957		CATHOLIC CHURCH		JAMES J. CONNOLLY		JAMES J. CONNOLLY		JAMES J. CONNOLLY		CATHOLIC CHURCH	

BUREAU V. 2

OCT 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09737

9735

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>10 1/2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				d. STREET ADDRESS <u>121 W. Church</u>			
3. NAME OF DECEASED First <u>Emma</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Never employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Samuel I. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Ritter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Dr. Custis Jr. 1852 Columbia Rd. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis lungs & bone</u> DUE TO (c) <u>Carcinoma of Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 months</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1949</u> 19 <u>49</u> to <u>Sept 16</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 15</u> 19 <u>57</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace H. Custis, Jr.</u>				ADDRESS (Street, city or town, state) <u>1852 Columbia Rd NW</u> DATE SIGNED <u>9/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Horace H. Custis, Jr., 1852 Columbia Rd. N.W., Washington, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey + Son</u>				ADDRESS <u>1201 N. Market</u>		24a. REC'D BY REGISTRAR <u>Frances Potter</u> DATE <u>17 Sept 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>ET</u>	

CERTIFICATE OF DEATH

Frederick

Frederick
121 N. Church

X

BUREAU V. 3

SEP 20 1957

RECEIVED

9736

CERTIFICATE OF DEATH

Reg. Dist. No.

09738 16

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Belvoir	
3. NAME OF DECEASED (Type or print) First Winifred Middle Gay Last Tiller		4. DATE OF DEATH Month September Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1956
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Billie H. Tiller		14. MOTHER'S MAIDEN NAME Theda Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO 571.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Chylous Ascites and Diarrhea DUE TO (c) 2 mo		INTERVAL BETWEEN ONSET AND DEATH 3 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital hypoplasia CEREBELLUM		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **August 23, 1957**, to **September 13, 1957**, that I last saw the deceased alive on **September 13, 1957**, and that death occurred at **4:08 AM**, from the causes and on the date stated above.

ACTUAL SIGNATURE Nelson G. Richards M.D.	ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	DATE SIGNED 9/13/57
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22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 17 Sept 1957	22c. NAME OF CEMETERY OR CREMATORY Big Stone Gap	22d. LOCATION (City, town, or county) (State) BIG Stone GAP VIRGINIA
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23. FUNERAL DIRECTOR'S SIGNATURE Arnold Funeral Home	ADDRESS 816 H St NE Washington D.C.	24. REC'D BY REGISTRAR SEP 16 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson
--	---	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		MONTGOMERY	
SEX		MALE	
AGE		31 years	
DATE OF DEATH		September 12, 1957	
PLACE OF DEATH		The Clinical Center, Baltimore, Md.	
CAUSE OF DEATH		Myocardial Infarction	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEXT OF KIN		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF DISTRICT ATTORNEY		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF CITY CLERK		[Signature]	
SIGNATURE OF VICE MAYOR		[Signature]	
SIGNATURE OF MAYOR		[Signature]	

RECEIVED
SEP 16 1957
BUREAU V. 3

9737

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring- Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD# 1				d. STREET ADDRESS RFD # 1			
3. NAME OF DECEASED (Type or print) MARION DURY First Middle Last				4. DATE OF DEATH Sept. 8, Month Day Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1864		9. AGE (In years last birthday) 93 yrn.	IF UNDER 1 YEAR Months 0 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None- Artist		10b. KIND OF BUSINESS OR INDUSTRY Self Emp. None		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Watson				14. MOTHER'S MAIDEN NAME Elizabeth McDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Pat O'Neil-Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO 15 min (c) Cerebral Arteriosclerosis Indif							INTERVAL BETWEEN ONSET AND DEATH 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fr. of left femur							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/13/1956 , to 9/8/1957 , that I last saw the deceased alive on 9/8/1957 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones M.D.				ADDRESS (Street, city or town, state) Rockville Md. DATE SIGNED 9/9/57			
PHYSICIAN'S NAME (Type) Stephen N. Jones							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/9/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24. REGISTRAR'S SIGNATURE James Potter			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

775107 101

0111715

100-10111-10708

Environ Biol Fish (2015) 98:103–110

England

1244

NOTES: 1. 11/11/11

See also 1041-1157

5107

0.2

REAU V. S.

EP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9738

CERTIFICATE OF DEATH

09740

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE 1615.2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>20008 ERIE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>WEEKS</u> Last <u>WEEKS</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7-1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WALTER NIXON GRAY</u>				14. MOTHER'S MAIDEN NAME <u>MARY RITTENHOUSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>SON</u> Address <u>20008 ERIE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis Anterior Descending Coronary Artery</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u> Interval between onset and death <u>12 hours</u> <u>12 hours</u> <u>several years</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ventricular aneurysm, left ventricular wall</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 1956</u> to <u>Sept 25, 1957</u> , that I last saw the deceased alive on <u>Sept 24, 1957</u> , and that death occurred at <u>12:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael D. Healy M.D.</u>				ADDRESS (Street, city or town, state) <u>Washington Circle Wash DC</u> DATE SIGNED <u>Sept 25, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Michael D. Healy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunmore</u>		22d. LOCATION (City, town, or county) (State) <u>Dunmore Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee's</u> ADDRESS <u>300 Fourth St. NE, Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Leslie Thompson</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9622

CERTIFICATE OF DEATH

Reg. Dist. No.

0974813

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 W. Montgomery Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle TALBOTT Last WELSH		4. DATE OF DEATH Month SEPTEMBER Day 30 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 16, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. Maurice Talbott		14. MOTHER'S MAIDEN NAME Cora Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Barnard T. Welsh, 301 W. Montgomery Ave. Rockville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH few weeks 2 1/2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1957 to Sept. 30, 1957 , that I last saw the deceased alive on September 30, 1957 , and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave., Baltimore, Md. DATE SIGNED 9/30/57 ACTUAL SIGNATURE Wm. A. Linthicum M.D. PHYSICIAN'S NAME (Type) Wm. A. Linthicum			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/3/57	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR 1 OCT 4 1957	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE Laurel K. Knapton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1880		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
Carpenter		Heart Disease		Natural		JAN 20 1925		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE	
High School		Roman Catholic		White		White		5' 8"		160 lbs		98.6		72	
MARRIAGE		SPOUSE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE			
Married		Mary H. Harris		JAN 15 1905		NEW YORK		NEW YORK		NEW YORK		UNITED STATES			
PREVIOUS MARRIAGES		PREVIOUS SPOUSES		DATE OF PREVIOUS MARRIAGE		PLACE OF PREVIOUS MARRIAGE		CITY OF PREVIOUS MARRIAGE		STATE OF PREVIOUS MARRIAGE		COUNTRY OF PREVIOUS MARRIAGE			
None		None		None		None		None		None		None			
SIGATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. S.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 8 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09741

9739

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>2715 Navarre Drive</u>				d. STREET ADDRESS <u>2715 Navarre Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Leong</u> Middle <u>Shue</u> Last <u>Wen</u>				4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Chinese</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1887</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>China</u>		12. CITIZEN OF WHAT COUNTRY? <u>China</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Betty Jean Wen 8418 Donnybrook Dr. Cherry Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive & Coronary Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lymphosarcoma - Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>57</u> , and that death occurred at <u>7:30 p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>901 20th NW, Wash DC</u> DATE SIGNED <u>9/21/57</u>							
ACTUAL SIGNATURE <u>Maurice Franks</u>				PHYSICIAN'S NAME (Type) <u>Maurice Franks</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU V.

9616

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>32 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				e. STREET ADDRESS <u>7132-Carroll Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>(no middle name)</u> Middle <u>Westberg</u> Last				4. DATE OF DEATH <u>Sept.</u> Month <u>1</u> Day <u>1957</u> Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Sweden / Denmark</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>Sven Andersen</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Hansen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wash. San. & Hosp. Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Gall Bladder with</u> <u>155x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mutators</u> DUE TO (c) <u>Hypostatic Pneumonia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>Apr 1957</u> <u>Aug 30 1957</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/31/1957</u> to <u>8/31/1957</u> , that I last saw the deceased alive on <u>8/31/1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T. Morse</u>				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave Takoma Park Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berge Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Palmer</u> ADDRESS <u>254 Carroll St D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. H. Hall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is partially filled out with handwritten text.

DECEASED

DATE OF DEATH SEP 5 1957

BUREAU V. 3

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9740 CERTIFICATE OF DEATH

09743

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7945 Old Georgetown Road				d. STREET ADDRESS 7945 Old Georgetown Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KATE WHEELER				4. DATE OF DEATH Sept 20 1957.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/1870	
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR 11 Months 18 Days		IF UNDER 24 HRS. 11 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alexandria Brooks				14. MOTHER'S MAIDEN NAME Lucy Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Baxter Address same as Item # 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Pneumonia. DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 Days. 10 yr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug., 1957. to 20 Sep., 1957. that I last saw the deceased alive on 15 Sept., 1957. and that death occurred at 10 PM. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14 Md. DATE SIGNED 20 Sept 57							
ACTUAL SIGNATURE John G. Ball				M.D. 7936 Georgetown Rd			
PHYSICIAN'S NAME (Type) John G. Ball							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 9/23/57		22c. NAME OF CEMETERY OR CREMATORY Private		22d. LOCATION (City, town, or county) (State) Spotsylvania County, Va	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 9-21-57 24b. REGISTRAR'S SIGNATURE Theresa M. Thompson	

SEP 24 1957

RECEIVED

09744

9741

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>75 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. STREET ADDRESS <u>Route # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Belle</u> Last <u>Whetzel</u>				4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1908</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Alice Feathers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ureteral obstruction and hydrocephalus</u> (c) <u>Carcinoma of Cervix</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1-3 mos</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ileovaginal fistula</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 19</u> , 19 <u>57</u> , to <u>September 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>September 2</u> , 19 <u>57</u> , and that death occurred at <u>8:15 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Couch</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT B. COUCH</u>				DATE SIGNED <u>9/2/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jenkins Chapel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mathias, W.Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wisconsin Ave</u> <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9-4-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NO 21. 188

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Robert A. Pippenger

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9742

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4534 Avondale St.</u>	
3. NAME OF DECEASED (Type or print) <u>Jetta</u> First <u>Whitney</u> Last		4. DATE OF DEATH <u>Sept</u> Month <u>7</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Norway</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lawrence Sivertsen</u>	
14. MOTHER'S MAIDEN NAME <u>Baroline</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Millie F. Whitney</u> Address <u>4534 Avondale St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular accident</u> DUE TO <u>9 wks</u> (c) <u>9 wks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>7-1-</u> 19 <u>57</u> , to <u>7-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>57</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>		DATE SIGNED <u>9/7/57</u>	
ACTUAL SIGNATURE <u>Wm. G. Hall</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wm. G. Hall</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>9-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Robert A. Fumfroy-Botson, Md.</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>37</i></p>	
<p>4. OCCUPATION <i>Police Officer</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. DATE OF BIRTH <i>1920</i></p>	
<p>7. PLACE OF DEATH <i>Home</i></p>		<p>8. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN <i>Wm. C. Hall</i></p>		<p>11. SIGNATURE OF REGISTRAR <i>Wm. C. Hall</i></p>		<p>12. DATE OF DEATH <i>8/10/57</i></p>	
<p>13. SIGNATURE OF DECEASED <i>Robert A. Fumfroy-Botson, Md.</i></p>		<p>14. SIGNATURE OF NEXT OF KIN <i>Robert A. Fumfroy-Botson, Md.</i></p>		<p>15. SIGNATURE OF WITNESSES <i>Robert A. Fumfroy-Botson, Md.</i></p>	

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SEP 9 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9743
CERTIFICATE OF DEATH

09746
215

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> (District of Columbia) b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 28</u> 16 x 2-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>1005 County Road, S.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Althea</u> Middle <u>Florence</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 March 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Steven DUNINGTON</u>		14. MOTHER'S MAIDEN NAME <u>Barbara (Last Name Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of anterior cerebral artery</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 August</u> , 19 <u>57</u> , to <u>13 Sept.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Sept.</u> , 19 <u>57</u> , and that death occurred at <u>11:55A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert G. Galbraith, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-13-57</u>			
ACTUAL SIGNATURE <u>Robert G. Galbraith, Jr.</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Galbraith, Jr., MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers, 517 11th St., S.E. Washington, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>9-13-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>			

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH—BUREAU OF VITALS

BUREAU V. S.

SEP 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9744

Item 4 File # 220 9-11-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

097452

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudon			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville--Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lucketts--Rural 83X-3			
c. LENGTH OF STAY IN b. 13 mth.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES First Buck Middle WILLIAMS Last				4. DATE OF DEATH September Month 1 Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880-?	
9. AGE (In years last birthday) 77 ? yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Leroy Cooper--Poolesville R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic poisoning 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic malignancy DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe anemia malnutrition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Aug. 19 57 , to 1 Sept. 19 57 , that I last saw the deceased alive on 29 Aug. 19 57 , and that death occurred at 7:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John G. Fawcett				ADDRESS (Street, city or town, state) P.O. Box, Maryland			
PHYSICIAN'S NAME (Type) JOHN G. FAWCETT				DATE SIGNED 9/2/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/57		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Lucketts, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hiltner, Bancroft, Md.				24a. REC'D BY REGISTRAR DATE 9/4/57		24b. REGISTRAR'S SIGNATURE Charles W. Elgin	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 10

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BUREAU V. 5

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9745

CERTIFICATE OF DEATH

09749217
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month September Day 3 Year 19 57		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 8/30/57 9. AGE (In years last birthday) yrs. 5 10. IF UNDER 1 YEAR Months 5 11. IF UNDER 24 HRS. Hours 5 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Hicks Wilson		14. MOTHER'S MAIDEN NAME Eva June Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mother 17. INFORMANT Same Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Heart Disease, Trauma 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Complete Transposition of Aorta and Pulmonary Artery (c) Pulmonary Artery		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE G. F. Mondore, M. D.		M.D. _____	
PHYSICIAN'S NAME (Type) G. F. Mondore, M. D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-5-1957	
22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz ADDRESS Winfield, Md.		24. REC'D BY REGISTRAR SEP 6 1957 24b. REGISTRAR'S SIGNATURE Arthur Lawler	

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BUREAU V. S.

SEP 6 1957

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10974

9746

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institutional Residence before admission) o. STATE New Mexico b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Albuquerque 682-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 318 Mulberry, S. E.	
3. NAME OF DECEASED (Type or print) First Isabel Middle Bessie Last Yoder		4. DATE OF DEATH Month September Day 12, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1929
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Olguin		14. MOTHER'S MAIDEN NAME Ania Chaves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 525-48-7911	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 754.2 DUE TO Post-operative hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonic stenosis, ventricular and interatrial septal defect (c) Congenital		INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 25, 1957 , to September 12, 1957 , that I last saw the deceased alive on September 12, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James A. McFarland M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 9/12/57	
PHYSICIAN'S NAME (Type) /s/ James A. McFarland, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 9/12/57		22b. DATE THEREOF 9/12/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Bernandillo Co. New Mexico	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR OCT 8 1957	
		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		Male		35		1920		New York City	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 Main St., Boston		Teacher		Heart Disease		Natural		Boston, Mass.	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
1957		10:30 AM		10		30		00	
DAY OF DEATH		MONTH OF DEATH		YEAR OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
10		10		1957		10		30	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

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OCT 8 1957

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